University of Alberta

An Assessment of the Quality of Health Care for Ugandan Rural Women, from a gender Perspective

by

William Rutakumwa ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Science

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ABSTRACT

This study assesses the quality of health care for Ugandan rural women from a gender perspective. The study was prompted by the fact that the health status for rural women has continued to be poor, in spite of a variety of services provided by the health care system. Qualitative research methods, particularly the grounded theory, were used to analyse the nature, relevance and extent of the health care services that are available for rural women. This study examines the perceptions of rural women (n=80) in Kasana and Kasokwe study sites in the Mukono District of Uganda, and those of health care providers (n=21) in the same district, regarding rural women's health problems and needs, and the available health care services. The findings reveal deficiencies in both quality and quantity of the services in rural Uganda, as the services are largely not gender sensitive, especially in regard to Family Planning use, abdominal pain among women, and stress. In this study, an appropriate approach to health care delivery and promotion in rural Uganda is suggested. Related policy recommendations and future research directions are also presented.

DEDICATION

I dedicate this thesis in loving memory of my late mother.

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The accomplishment of my thesis work has yet again demonstrated to me that there are so many kind souls in this world. If I had to acknowledge each of those persons who contributed to this work, this space would no doubt be too small. It is for this reason that I mention only a few categories of people. First of all I would like to thank Dr. Naomi Krogman, my supervisor, for her invaluable support and advice. You have made my academic experience in Canada a wonderful one. I also thank my supervisory committee members, Dr.s N. Gibson, K. Travers, and D. Davidson. Thank you for your input. Other Rural Economy Departmental staff members that are worth mentioning include Mr. R. Page, M/s L. Bruce, M/s M. Stegmeier, and J. Boucher. Thank you giving me the audience I have had to seek from you every so often.

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CHAPTER I: INTRODUCTION

1.1. Overview.

This thesis represents a study of the compatibility between the existing health care services and the health needs of Ugandan rural women. While the study of gender and health, and community-based health care have received attention since the 1970's, there are few studies that have critically addressed women's health care needs in rural Uganda. Limited government funding for rural health care, and an increase in rural Ugandan population, make it all the more important that the limited health care services provided are well suited and effective for the rural population. This study represents a qualitative research project in which 80 rural women and 21 health care providers in Mukono District were interviewed to provide details about the suitability of the existing health care services, vis-a-vis the high priority health care needs of rural women.

1.2. Background of the problem.

Globally, women tend to suffer from a variety of health problems specific to their gender. These health problems have perpetually undermined women's physical and mental health. In Uganda, women's general welfare is a priority for the government, as evidenced by the government's efforts to raise women's status through economic and political emancipation. The Ugandan government is encouraging and supporting income generation projects and credit extension schemes especially for rural women. In politics, the government has adopted affirmative action policies since its inception in 1986 to improve women's participation in the politics of the country. The National

Resistance Council Statutes 1 and 9 provide for a specific number of seats to be reserved for women at all levels of political representation.

Despite these hopeful gains for women, my examination of the health care services vis-à-vis the rural women's health care needs reveals that women's health has not been effectively addressed by the government. Although there has been a remarkable effort to improve women's health through such activities as the training of rural women under the Primary Health Care (PHC) arrangement, and the training of Traditional Birth Attendants (TBA's), other important aspects of women's reproductive health have not received adequate attention. In addition, the referral system does not seem to be operating effectively in rural areas, particularly my study site in the Mukono District of Uganda.

Overall, the national health care delivery system reflects an underlying lack of recognition that the health needs of women differ significantly from those of men. Also lacking is the recognition of women's potential (as recipients of services) to provide valuable input in designing appropriate health policies. This study reveals that women's health problems remain largely unknown and/or misunderstood because of the above situation.

1.3. Study area.

1.3.1. Summary about the country.

Uganda is located in the east of Africa. The country shares borders with the Sudan in the north, Tanzania in the south, the Democratic Republic of Congo in the east, and Kenya in the west. According to the World Bank report for the year

1998/1999 (World Bank, 1998), Uganda's population as of 1997 was 20,320,000, with an average annual growth rate of 3.2%. During the period 1991-1997, the percentage of the population below two thirds of the national mean per capita income was 16% and 46% for the urban and rural populations respectively. Overall, the Gross National Product (GNP) per capita for the year 1997 was $330 US, approximately $485 CAN. The literature review chapter provides details of health and other related statistics.

1.3.2. District study setting.

Much of the information about the study setting has been adopted from the 1997/98 edition of the Uganda Districts Information Handbook (Mugisha, 1997), and my own field research findings.

1.3.2.1. Location and population.

The Mukono District is located in the central region of Uganda (see figures 1 and 2 for the Uganda and Mukono District maps), with a surface area of 14,242 square kilometres. The district has six counties, namely, Bbale, Buikwe, Buvuma Island, Nakifuma, Ntenjeru, and Mukono. These counties are further divided into 30 sub-counties. The study sites, Kasana and Kasokwe Parishes, are located in Nakifuma and Bbale Counties respectively. As illustrated on the map, the district shares borders with Jinja and Kamuli districts in the east, and Kampala, Mpigi, Luwero, and Nakasongola districts in the west. In the north and south of the district are Lakes Kyoga and Victoria respectively.

Mukono district forms part of the region whose traditional inhabitants are Baganda (one of Uganda's ethnic groups), and therefore the main dialect is Luganda.

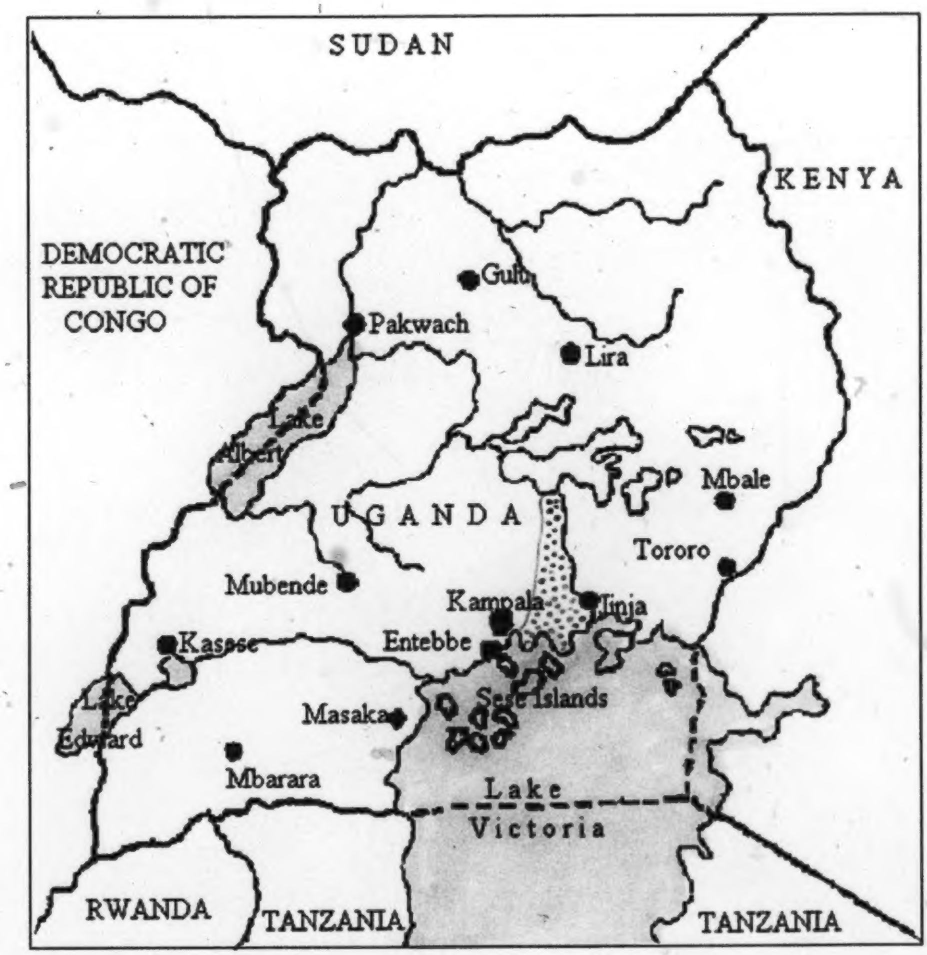

Figure 1: Map of Uganda featuring Mukono District Study Site (dotted)

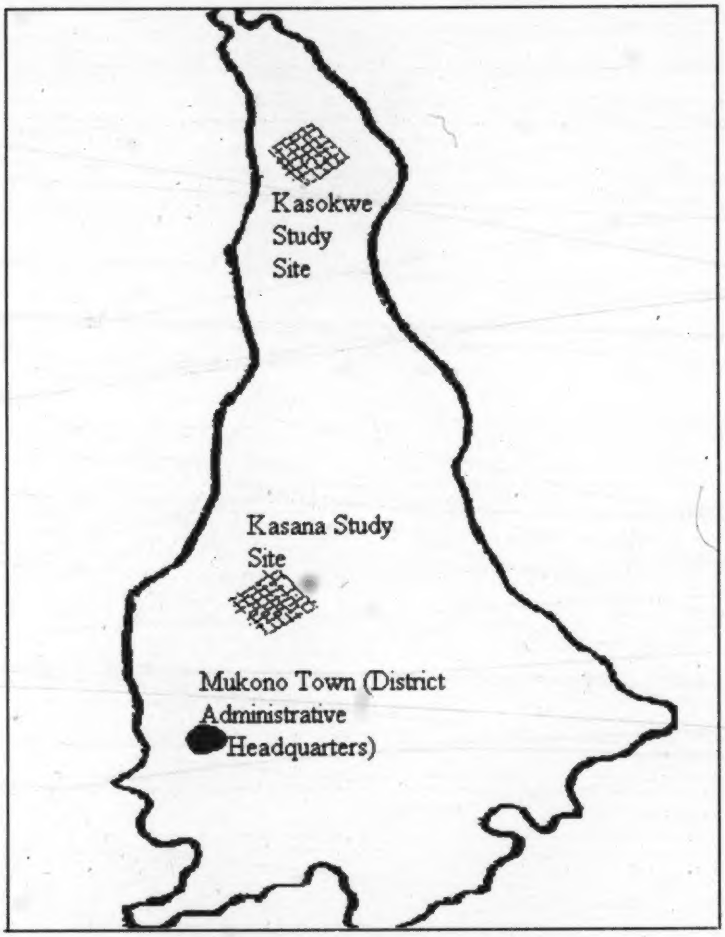

Figure 2: Mukono District Map featuring the two Study Sites

However, the northern parts of the district are multi-ethnic with the Banyankore, one of the major ethnic groups in the western part of Uganda, and ethnic Rwandese, as one of the more well known ethnic groups. Ethnic diversity also exists in Kasokwe study site, which is located near the northernmost part of the district. Nonetheless, Luganda remains the major dialect in this study site, as evidenced by the fact that it was preferred by all of the interviewees.

The district's population is 824,604 and 49.8% are female. The majority of the district's population, that is, 88%, dwell in the rural areas of the district. Mukono town is the district's administrative headquarters. Other major towns in the district include Njeru, Lugazi, Kayunga, Seeta, Nakifuma, Kyerima, and Kangulumira.

1.3.2.2. Relief, climate, land use, and economic activities.

Mukono District lies at an altitudinal range of 1,158 metres and 1,219 metres above sea level. The district usually experiences high temperatures and heavy rainfall. Rainfall peaks are experienced in April/May and October/November. In the study sites, abnormally dry conditions have been experienced lately as reported by the study population. According to the population, this drought has had a negative impact on agricultural production. The area under forest cover is 123,820 hectares, about 9% of the Mukono District area.

Agriculture is the population's main economic activity. The district's food crops include cassava, sweet potatoes, beans, maize, finger millet, ground nuts, soya beans, bananas, sorghum, simsim, cowpeas, pigeon peas, and yams. The cash crops include cotton, coffee, sugar cane, and tea. Fruits and vegetables include tomatoes, onions, pineapples, vanilla, passion fruits, and cabbages. Dairy farming is another economic activity. The district's cattle population is estimated at 81,294 heads. I was unable to access information about the percentage of families that are involved in dairy farming.

Apart from agriculture, the population engages in fishing on Lake Victoria. There is also some industrial activity in the district involving processing of coffee, sugar, and tea. Manufacturing industries include Nyanza Textile Industries (NYTIL), Lugazi Sugar Works, and Nile Breweries. Other industrial activities include grain milling, furniture works, metal works, and animal feed manufacturing. I was unable to access information on gender distribution in formal and informal labour.

1.3.2.3. Infrastructure.

The district has four hospitals, namely; Kayunga, Kawolo, Nagalama, and Nkokonjeru hospitals. Kayunga and Nagalama are the relatively accessible hospitals for the population in the two study sites. Other health facilities include health centres, dispensaries, clinics and aidposts. Much of the district's road network is not tarmac and rural communities are not adequately covered by public transport services. This is more evident with Kasokwe study site. This situation contributes to the problem of inaccessibility to health care facilities by the rural population. The district has 590 Primary (Elementary) Schools, 31 Secondary Schools, and two Teacher Training Colleges.

1.4. Statement of the problem.

The health of rural women especially in developing countries has continued to be poor (MacMillan and Ndegwa, 1996; Okojie, 1994; Poostchi, 1986; Raikes, 1989; Turshen, 1991) in spite of the presence of a variety of health care services in these countries. In several developing countries, these health care services are inadequate, poor, or not available. The 1997 United Nations Human Development Report reveals that of all births during the period 1990-1996 in Uganda, only 38% were attended by trained health personnel (United Nations, 1997). Dixon-Mueller (1994) reports that in developing countries many Family Planning (FP) programs have been found to offer little or no personal counselling, method choice, or follow-up care, which in turn has caused FP program failure in these countries. This failure is reflected in the low percentage of FP use among women. Kilian et al. (1997) report a 1995 survey which revealed that only 5.1% of Ugandan rural women use modern methods of contraception. Okojie (1994) reports that 32% of the women in developing countries live under restrictive abortion laws, and thus, do not have access to safe abortion services. As in several other developing countries, Ugandan rural women's health problems generally include both reproductive and non-reproductive health problems, and stress. In spite of this health situation, the available health care services do not seem to be effectively tailored to the needs of the women and consequently there exists a wide gap between the needs and the services.

1.5. Research questions.

The general research questions for this study include: What are the common health problems and needs of Ugandan rural women? What is the nature and type of health care services that are available for the rural women? How accessible are the existing health care services to the rural women? What is the nature of the gap between the existing health care services and the health needs of the rural women? What are the rural women's perspectives on recommendations for changes to the current health care delivery system?

It will be noted that almost all of the above research questions can only be exhaustively answered by the rural women who are expected to have broad knowledge about their own health problems and needs, as well as their health care services. The purpose of this study was to assess the quality of health care for Ugandan rural women. In light of the health problems and needs as revealed by the women, a critical analysis of the organisation, type, and provision of health care services was made.

1.6. Research objectives.

The objectives of this research project include: (a) providing a detailed picture of the health needs of Ugandan rural women and the available health care services; (b) identifying the gaps in health service accessibility and delivery as perceived by rural women and health care providers; and (c) recommending strategies to improve service delivery and women's health.

In order to fully realise the above objectives, qualitative research methods, particularly grounded theory, were used to collect data from rural women participants and health care providers. From the sample frame, rural women participants were chosen by random sampling, while health care providers were chosen from those who provide specialised services for women. Both individual and focus group interviews were conducted. Other sources of data included the Health Ministry's *Procedure*

Manual for Family Planning and Maternal Health Service Delivery (MOH & INTRAH, 1995).

1.7. Significance of the study.

In order to provide services that are relevant to women's health care needs, it is important to first address the question: what are women's health problems and needs? Since the answer to this question has traditionally been provided by health care providers, rather than health care recipients, a study of recipients' perceptions is timely and useful. The lack of input by the rural people, particularly women, could partly explain why women's health has remained poor, in spite of the existing health services. The inadequate knowledge about women's health problems and needs has been pointed out by many health researchers (Muecke, 1996; Eide & Steady, 1980; AbouZahr, Vlassoff & Kumar, 1996) as one crucial area that needs to be addressed. This view has been echoed at international and national fora such as the 1994 World Health Organisation Workshop held in Budapest, Hungary (Muecke, 1996), and the Second Meeting of National Leaders in Women's Health at the University of Florida (Health Science Centre, 1997). This study seeks to address the problem of inadequate knowledge by exploring an important source of information (recipients of services) that has traditionally been ignored by service providers and researchers.

1.8. Thesis outline.

This thesis has been presented in the following format. Chapter II, the literature review, explores the existing literature about women's health, services and related research. In this chapter, a definition of important terms is provided. Different models of health care/promotion are examined, after which, an approach that seeks to integrate these models is recommended for developing countries, such as Uganda. This is followed by a history of Uganda's health care system vis-à-vis the present system. Women's health problems are reviewed. The existing gaps in women's health care research are explored and a more appropriate research approach is suggested. Lastly, an overview of the theoretical orientation is presented.

Chapter III presents the research methods that were used. The objectives of this study are revisited. Method choices are discussed and the rationale is provided for the choices taken. This is followed by a chronological presentation of the research activities. The issue of trustworthiness of the findings is discussed as well as strengths and weaknesses of this study.

The findings of this study are presented in chapter IV. This chapter begins with a restatement of the research problem. This is followed by a presentation of the context and conditions within which the rural women live and work. The coping strategies adopted by the women are identified. The latter part of this chapter reports rural women's perspectives on their health problems and needs, the health care services available to them, and their recommendations for change to improve services. The health care providers' perspectives on the women's views and the providers' recommendations are also reported.

Chapter V discusses the findings. The chapter begins with a restatement of the purpose of the study and data collection methods. A summary of the findings is presented, followed by a detailed discussion of the findings. The emerging theory is presented. Also discussed are the implications of the findings for the community-based health care approach, and how the approach can be tailored to suit Uganda's conditions. The last part of this chapter highlights three important aspects of women's health that call for more emphasis. It is in this chapter that an assessment of the quality of health care for Ugandan rural women is made.

The conclusions of this study are presented in chapter six. This chapter begins with a summary of the findings as they relate to this study's research questions and the objectives. This is followed by recommendations for improvement of health care service delivery. Lastly, future research directions are suggested.

CHAPTER II: LITERATURE REVIEW

2.1. Introduction.

In this chapter, definitions of important keywords and phrases are given. Different models of health care/promotion are discussed, and an appropriate approach that seeks to integrate the useful aspects of all the other models is suggested for developing countries such as Uganda. This is followed by a history of Uganda's health care system as compared to the present system. An overview of women's health problems is provided. The existing gaps in women's health care research are explored, and lastly, I present an overview of the theoretical orientation of this study.

2.2. Definition of keywords and phrases.

2.2.1. Health.

Health can be defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO Basic Documents, 1989). This definition highlights the various aspects of health and that in order to understand the health status of individuals or groups of people it is imperative to address all the above aspects. Broadly, Tarlov (1996) defines health as "the capacity, relative to potential and aspirations, for living fully in the social environment" (p. 72). This definition demonstrates that absence of disease or infirmity is just one step in achieving health, and that individuals or the population must also be able to realise their full potential and aspirations in their daily lives. It is important to note that the presence or absence of health is a result of several health determinants including "genetics, environmental factors, the health care system and socio-economic factors"

(Miller, 1994, p. 201). Therefore, as opposed to the popular belief which equates the level of health with the quality of medicine (Lalonde, 1994), medical care is just one of the health determinants (Monekosso, 1989, p.5). While recognising the above fact, this study only addresses health care with specific focus on rural women's health care services in Uganda.

2.2.2. Gender.

The term *gender* is used to signify ideas and expectations about women and men, and girls and boys, that are shared in society; that is, what is typically feminine or masculine and the assumptions about how people of different sexes and sexual orientations should relate to each other and behave in various situations (Muecke, 1996). For instance, the role expectation of men as decision-makers and women as decision-takers has served to undermine the health status of women in developing countries. A case in point is that men/husbands determine when their spouses should seek care, thereby controlling access to biomedical health care (Mebrahtu, 1991, p. 96).

2.2.3. Gender perspective.

Gender perspective refers to a way of perceiving oneself and others that takes into account societal distinctions between women and men (Muecke, 1996). This perspective is premised on feminist thought. According to Flax (1986), feminist theory assumes that men and women have different experiences; that the world is not the same for men and women (p. 3). In line with feminist theory, the gender perspective recognises that health problems and needs are not entirely the same for men and women; gender relations between providers and recipients are an important factor in health care delivery; and that the health service providers' perception of the level of wellness may not necessarily be the same as that of the recipients (women).

2.3. Models of health care/promotion.

Three models of health care/promotion are presented, namely; the biomedical, behavioural, and socio-environmental models. Arguments supporting the integration of the above models, particularly when dealing with women's health, are presented. The community-based health care approach is suggested as a suitable framework within which to realise this objective. It is expected that within the above framework, efforts to provide accessible, low cost health care to the rural population can be realised.

2.3.1. Biomedical model.

The biomedical model is oriented to disease-prevention, detection and treatment. This model focuses on individuals because of the perception that disease and health are physiologically-based, and it views health determinants as related to disease-causing agents. A major advantage of this model is its responsibility for the production of detailed knowledge about treatments and cures of various diseases, including the eradication of fatal diseases such as small pox.

However, critics have identified several limitations with this model. According to Nettleton (1995), the apparently dominant biomedical model implies: "that diseases exist as distinct entities; that those entities are revealed through the inspection of 'signs' and 'symptoms'; that the individual patient is a more or less passive site of disease manifestation; and that diseases are to be understood as categorical departures or deviations from 'normality'" (p. 3). With the above description, the author implies that the model is narrow-focused in a sense that it isolates disease from (arguably more) important social determinants of health. Similar limitations were identified by Ruzek, Clarke, and Olesen, (1997). The authors argue that the model inadequately represents health care because it leaves out, or nominally considers the social forces and contexts that shape women's health (p. 12). Nettleton's (1995) summary of these limitations is that "the body is isolated from the person, the social and material causes of disease are neglected, and the subjective interpretations and meanings of health and illness are deemed irrelevant" (p. 3). The inadequacy of the biomedical model assumes greater significance when dealing with health in the developing world, as material causes play a significant role in determining population health.

2.3.2. Behavioural model.

The behavioural model is oriented to disease prevention and physical well-being. This model views health determinants as related to individual lifestyles, and seeks to promote health-enhancing lifestyles with a view to preventing disease and promoting physical well-being. The model is advantageous to the extent that it recognises individual behaviour as a health risk factor. This behavioural perspective has yielded some positive results in health promotion. A case in point is the adoption of the behavioural change strategy to fight against Acquired Immune Deficiency Syndrome (AIDS) virus in Uganda. In an article entitled "Uganda's successful anti-AIDS program targets youth," published by Cable News Network (CNN), 3

September 1999, Hunter-Gault reported that "Uganda has one of the most aggressive, and some say most effective, AIDS control programs in the world"

However, the behavioural model is inadequate because of its inherent lack of recognition that human behaviour and action is influenced by society. Ruzek (1997) argues that a woman's social relationships, family responsibilities, and other living and working conditions all affect her behaviour. The author adds that "larger structural factors such as poverty, employment opportunities, and environmental conditions also shape how individual women protect or compromise their own health" (p. 119). Since the majority of women in developing countries like Uganda live in poverty and unhealthy physical environments, an appropriate model for health care/promotion would necessarily recognise the pivotal role played by these factors in determining women's health.

2.3.3. Socio-environmental model.

The socio-environmental model has a broad focus on society, not simply on individuals. Under this model, health and disease are conceived in a socio-environmental context. It is argued that health is determined by the socio-environmental setting in which an individual or a population lives. The model has been a result of the growing effort by health planners to develop new health care models that recognise the multidisciplinary nature of health determinants. This effort is evidenced by various international health promotion declarations, such as the 1997 Jakarta Declaration on Health Promotion into the 21st Century. Uganda has since adopted the Primary Health Care approach, though not much success has yet been registered. The socio-environmental model seeks to promote health by addressing the social, economic, and environmental determinants of health, such as culture, physical environment, and violence against women. Other socio-environmental determinants include poverty, women's empowerment, and social relations.

It is pointed out in the Jakarta Declaration of 1997 (WHO, 1997) that "poverty is the greatest threat to health" (p. 1). Mustard and Frank (1994) state that "there is a long history of reports and studies outlining the association between poor health and the lowest socio-economic strata of society" (p. 13). As Wallerstein and Bernstein (1988) add, research has documented that poor socio-economic status is related to increased morbidity and mortality from such risks as improper sanitation, hazardous jobs, malnutrition, and poor education (p. 380).

The socio-environmental model recognises that the level of women's empowerment determines health, especially for the women and children. Using the definition by Israel et al. (1994), empowerment may be referred to as the individual's ability to make decisions and have control over his or her personal life. Caldwell (1989) observes that "a marked degree of female autonomy is probably central to exceptional mortality declines, especially in poor but open societies" (p. 15). The author points out a number of socially and culturally constructed issues such as scandals about unmarried girls assuming roles outside the house when they have reached puberty, older women appearing in public on their own initiative, and women assuming autonomy from their husbands, fathers, mothers or brothers. The author explains that such issues determine the number of years girls spend at school, women's ability to take independent action about sick children or about themselves, and equal treatment of daughters and sons in terms of feeding and medical services.

According to House et al. (1988), recent scientific work has both a theoretical basis and strong empirical evidence for a causal impact of social relationships on health. Berkman and Syme (1979) report that people who lacked social and community ties were more likely to die earlier than those with extensive contacts. Lin and Ensel's (1989) study corroborated the above results. Wilkinson's (1996) study found that the strength of interpersonal and family and community cohesiveness served to counteract the effects of life stress, and that this served as a protection against heart disease. Other corroborating studies include those of Kobrin and Hendershot (1977), Breault (1986), and Rahman (1993). The fact that many rural women in developing countries live and work within their domestic confines implies that the women do not have adequate time to build health-enhancing social relationships.

It is important to note that none of the above models can provide solutions to today's multidimensional health problems. While examining the behavioural versus socio-environmental models, Ruzek (1997) takes the view that neither a purely structural (socio-environmental) nor an individual (behavioural) paradigm adequately addresses real women's health needs (p. 120). The author adds that by envisioning individual and structural approaches as complementary, rather than oppositional, more opportunities will be opened up for women to improve their personal health.

Tesh (1988) argues that progressive policy analysts who favour shifting responsibility for disease prevention from the individual to the society misunderstand the dialectical relationship between people and their social world. The author adds that in that relationship each element creates the other (p. 5). In other words, the individual and the society have an influence on each other. Thus, viable program interventions for disease prevention would not focus on any of the two in isolation of the other, rather, the focus would be on both.

Ruzek et al (1997) attempt to integrate the aspects of all the above models. The authors state that such an integrated approach to women's health would "address the contributions of socially and culturally constructed concepts of caring and curing as well as health practices, medical care, and the social investments in the prerequisites for health" (p. 11). The authors cite seven content areas for the model that would effectively address women's health. These include: reproductive health, diseases more common in women than men, leading causes of death among women, gender influences on health risk, societal influences on women's health (norms, roles, and poverty), violence against women, and women and health care policy.

2.3.4. Community-based health care approach.

The community-based health care approach seems to represent the effort by health planners to develop approaches that integrate the biomedical, behavioural, and socio-environmental aspects. According to Pong et al. (1995), community-based health care means bringing health services as close as possible to where people live and work and providing health services outside hospitals and other institutions. The authors add that this approach emphasises consumer participation, holistic and team approaches, a more rational use of health resources, greater responsibility by individuals for their well-being and a disease prevention and health promotion orientation.

In this approach, biomedical aspects such as ambulatory care, acute and specialised services, rehabilitative services, and self-care, are addressed together with the socio-environmental and behavioural aspects such as disease prevention, health promotion, and community support (Pong et al. 1995). By addressing ambulatory care and self-care, this approach seems to be the most appropriate for developing countries where failure to promptly access health care is one of the significant causes of mortality, especially in the case of rural women.

According to Dodge and Wiebe (1985), the need for the community-based health care approach has been a consistently emerging theme in various research studies. The authors state that various studies conducted in Uganda by doctors, scholars, development and relief workers, aid administrators, and consultants have consistently identified "the importance of health services initiated 'by' and not 'for' the people, and of community-based rather than vertical interventions" (p. 6).

A similar approach, the *community health care* approach has been adopted in many developing countries (Golladay, 1984) including Uganda. The success of this approach has been curtailed largely by limited transport, inadequate and erratic supplies, and too few and hastily trained health workers (Golladay, 1984) in rural areas of Uganda. In these rural areas, limited transport is usually a result of impassable roads or the fact that public transporters find it unprofitable to operate in these areas.

This is more so in view of the fact that there is currently no government-operated public road transport system in Uganda, which should have been more service-oriented than profit-oriented. Inadequate and erratic supplies is a significant problem in rural Uganda, as many of the rural health care facilities usually lack the drugs that are usually required by the rural communities. On the other hand, rural health facilities are characterised by inadequate staff and inadequately trained health workers. Golladay (1984) points out that community health workers are not trained in the diagnosis and treatment of locally important diseases (p. 244). Notwithstanding the above constraints, this approach has a potential for success if the government addresses these constraints as priority issues.

In their literature review, Pong et al. (1995) specifically highlight the importance of the health human resources in community-based health care. The authors explain this continuum as "the range of practitioners or caregivers relied upon to deliver health care or to achieve health objectives" (p. 10). The development of this range of human resources is of critical importance because the community-based health care model calls for active involvement of not only health care professionals, but also community members in their own health care and promotion.

With this approach, all those individuals or groups of people who participate in the provision of health care are recognised as part of the health human resources continuum. The recognition of the health human resources continuum represents a fundamental shift from viewing the resources as constituting only formal caregivers to a more appropriate view that considers informal and self-caregivers as part of these resources. In the case of developing countries like Uganda whose rural communities have a significantly unmet need for health education, significant effort is needed to develop these important resources. The recognition of this continuum means that the hitherto unrecognised, yet significant health care contribution by rural women in developing countries becomes a priority issue. This would then call for health education and training of the women in order for the women to perform better. In support of the above view, the World Health Organisation's (1990) definition of the term 'human resources for health' encompasses all those who contribute to the objectives of the health system, including those who have formal health-related training and work in the organised health sector, as well as those in the informal health sector (Pong et al., p. 10).

By demonstrating that the biomedical, behavioural, and socio-environmental models can be complementary, not competitive, the community-based health care approach seems to offer a much better option for health care delivery. Under the framework whereby health care is provided outside hospitals and institutions, there is likely to be promptness and increased coverage in the provision of medical care to rural people of the developing world. This view is reinforced by research work which has concluded that utilisation of health care services in Africa declines by half for each two additional miles away from a health unit (Golladay, 1984, p. 240). In addition to its curative approach, the community-based health care framework would provide for non-medical health promotion activities such as health education and training.

2.4. A history of Uganda's health care system vis-à-vis the present system.

As at the beginning of the 1970's, "Uganda enjoyed a level of health services far superior to many other developing countries" (Scheyer & Dunlop, 1985, p.28-29). In their description of Uganda's health care system in the above period, the authors state that the government provided curative services without charge, in hospitals, health centres, dispensaries, subdispensaries, maternity centres and aid posts. The Catholic and the Protestant Church Medical Bureaus also provided curative health services for a small fee, through hospitals, subdispensaries and maternity centres. There were also a number of private practitioners in the larger cities and towns who provided a range of curative services to those capable of paying.

Government health facilities were integrated in such a way that an individual could be referred to a facility providing more intensive care or treatment than that offered by the facility originally attended. In addition, private physicians, mission facilities and other population-specific facilities could refer individuals to government facilities for certain specialised services. The most common referral relationship, however, existed between rural government health facilities and government district hospitals.

The authors add that preventive health services in Uganda were usually provided by local government-district administrations, municipalities and townships. Environmental health services such as sanitation, waste disposal, vector control and clean water supplies were administered by special health manpower headed by the health inspector. Antenatal clinics, young child clinics and immunisations (supported by the central government) were usually delivered through weekly clinics held at local health facilities (p. 28).

However, due to a history of political instability that Uganda has gone through, the quality of health care services in the country has been undermined. Notable experiences in Uganda's political history include the 1971-'79 military regime, and the 1980-'85 Obote II regime. The two regimes were both characterised by civil strife and increased military spending at the expense of health care. In the early 1980s, infrastructure such as roads had deteriorated and facilities and equipment in most hospitals and other service institutions had been destroyed (Dodge and Wiebe, 1985). As expected in conditions of strife, the economy declined mainly due to lack of trade and investment security. This worsened the government's ability (lack of foreign exchange) to procure essential drugs from outside the country.

By the mid-1980s, an estimated 70% of the population in developing countries did not have easy access to modern health care facilities (Golladay, 1984). The author notes that the supply of drugs and other essential materials in rural health facilities is often unreliable, and that this discourages patients from seeking care from these facilities. In addition, the available services are inadequate and frequently unaffordable to the rural people. Golladay also identifies the lack of roads and public transportation as major barriers curtailing the ability of vast numbers of rural patients to obtain more reliable health care outside their communities. Pregnant women and small children whose needs are greatest find travel especially difficult.

Although significant steps have been taken by the Ugandan government to improve this situation, much more is yet to be done. Presently, the government provides curative services at subsidised fees, but as already indicated, it is common for the government health care facilities to lack most of the required drugs, especially in rural areas. In such cases, patients resort to private drug shops where the prices of the drugs are usually not affordable to the rural patients. In addition to the government and other private health care providers, the Catholic and the Protestant Church Medical Bureaus provide paid services.

Preventive health services are not as efficient as they used to be. Many rural areas experience poor sanitation and unclean water supply (from wells, streams, rivers and lakes). Antenatal clinics are not easily accessible to the rural women residents. Similarly, young child clinics with specialised professionals are not common in rural areas of the country. Thus, the rural women usually take their sick children to general physicians who are not always trained adequately to handle such cases.

2.5. An overview of women's health problems.

The above state of the health care services in Uganda has been followed by a deterioration of population health. The worst hit have been the economically, socially and politically disadvantaged sections of the population, that is, women and children. Rural women in Uganda, as is typically the case with several other developing countries, have a variety of health problems. Okojie (1994) points out that women in these countries start bearing children during childhood and in most cases the birth spacing is close. Early child bearing has affected women's reproductive health, leading to premature deaths during labour, or from weakness and exhaustion due to frequent pregnancies. According to the United Nation's Human Development report (1997), Uganda's total fertility rate for 1994 was 7.1, which according to statistics ranked fourth from the highest rate among the list of developing countries. According to the 1999 World Health Report (WHO, 1999), the country's total fertility rate remained the same for the year 1998. The 1997 Human Development Report also reveals that of all births (during the period 1990-1996) in Uganda, only 38% were attended by trained health personnel. This generally exposes women to high maternal mortality risks. The report further reveals that the maternal mortality rate in Uganda during the year 1990 was 1,200 per 100,000 live births, which ranks sixth from the highest rate among the other listed developing countries. In support of the above statistics, a United Nations report (1995) reveals that maternal mortality is a leading cause of death for women of reproductive age in developing countries.

One of the measures to stem the high maternal mortality rate would perhaps be to establish abortion clinics, but as Okojie (1994) notes, most women in the developing world do not have access to safe abortion services. The author adds that 32% of the women in these countries live under restrictive abortion laws, while 10% live in areas where abortions are not legal for any reason (p.1243). Abortion is illegal in Uganda. A look at the existing Family Planning (FP) services in these developing countries reveals that the quality of care is still poor. Dixon-Mueller (1994) quotes the results of the World Fertility Survey conducted in the developing countries (in mid-80s) by the World Health Organisation. The results revealed that many FP programs offer little or no personal counselling, method choice, or follow-up care, and that FP providers are often more concerned with meeting the targeted numbers of "acceptors" than with meeting the needs of individual women (p. 196). The author adds that adolescent girls and unmarried women are not served by most FP programs as currently structured. According to a 1995 United Nations report on the world's women, a related finding was that "the success of the FP programs is often evaluated on the basis of contraceptive prevalence rates, usually calculated as the proportion of married women between the ages 15 and 44 using contraception" (p. 78). Although this situation is gradually changing in urban areas of Uganda where the youth are becoming one of the target populations, the FP programs have not yet effectively targeted rural youth. In these rural areas, premarital sex is more stigmatised than in urban areas, and rural adolescent girls and unmarried women rarely visit FP facilities. The failure by FP programmers to comprehensively address the reproductive health needs of women and girls might partly explain the poor reproductive health of Uganda's women, as reflected in the above statistics.

Infectious morbidity is another highly prevalent health problem among women in developing countries. This includes sexually transmitted diseases (STD's), and pelvic infections such as gonorrhoea, syphilis, genital herpes and others. According to Okojie (1994), women from Africa also reported frequent histories of STD's and more frequent complications of abortions or childbirth than women in other continents. Turshen (1991) reports that women account for at least half of the Acquired Immune Deficiency Syndrome (AIDS) cases in Africa. MacMillan and Ndegwa (1996) point out that African women have a higher incidence of Human

Immunodeficiency Virus (HIV) than their male counterparts. As in other African countries, the high prevalence of STD's is expected among Ugandan women.

Many women in developing countries suffer from nutritional morbidity (Poostchi, 1986; Raikes, 1989). "Poor nutrition and lack of foods lead to anaemia, exhaustion and a general wearing down, especially as women must often continue to perform heavy manual agricultural work together with all other household tasks, throughout their pregnancy and lactation periods" (Raikes, 1989, p.448). Okojie (1994) states that the two sources of nutritional morbidity in developing countries are inadequate caloric intake and nutritional anaemia (p. 1239). The author argues that insufficient calorie intake affects girls and women severely because of nutritional discrimination against them, that is, they eat less of the nutritious foods than their male counterparts. A World Health Organisation (WHO) review in 1985 estimated that half of all the African women suffer from nutritional anaemia (Okojie, 1994, p. 1239). It is expected that the practice of nutritional discrimination against females has not yet completely disappeared particularly in the rural areas of Uganda.

The existing health services in many developing countries do not seem to recognise women's nutrition as an important health issue to the women themselves. Mebrahtu (1991) points out that "maternal and child health programs focus on the child rather than the mother, and they generally treat maternal nutrition as a function of child welfare and nutrition" (p. 92). The author explains that "maternal nutrition focuses attention on women as mothers, and on their nutritional status as it relates to the bearing and nurturing of children" (p. 92). This implies that women's nutrition in developing countries is primarily for the welfare of their children, not themselves.

Poor nutrition has lowered women's body immunity, making them more vulnerable to common tropical diseases such as malaria and diarrhoea. Raikes (1992) argues that women in these countries tend to suffer in silence and do not seek treatment. He attributes this to the fact that the threshold of illness recognised by society on the illness-health continuum is so high for women that they endure severe pain in order to avoid disrupting household organisation. As in other developing countries, it is expected that this phenomenon prevails among women in Uganda.

Developing countries experience a high incidence of female mortality in childhood, which is mainly a result of the lower value attached to female children by society. This is evidenced by the fact that in 1990, the sex ratio in Africa was 98.7 girls per 100 boys (Sohoni, 1992). The author adds that more than women, girls bear the burden of discriminatory treatment, irrespective of societal or personal socio-economic levels (p. 4). The nutritional, educational, and health care provisions for girls are usually less than those for boys. This makes the girls more vulnerable, and thus, they are exposed to higher morbidity and mortality risks than boys.

Violence against women has been another cause of women's ill health (Smyke, 1991; Gerbert et al., 1996). This violence takes various forms involving physical and verbal abuse. The physical form includes wife-beating, female genital mutilation (female circumcision), and rape. In many developing countries, this violence has been condoned and/or supported by cultural beliefs. "The traditional tendency to consider women as subordinate to men has led to a perception of justification of traditional violent practices and gender-based violence, as a form of control or 'protection' of women" (Del Frate, 1995, p. 2). According to Heise et al (1994), a study conducted in Kampala (Uganda's capital) and published in 1991, revealed that out of a sample of 80 women, 46% reported having been physically abused by a partner; while 42% reported being regularly beaten by their partners (p. 1166). The situation is likely to be worse in rural areas of Uganda where cultures sanctioning male domination are largely intact.

Apart from domestic violence, violence and conflict at the national level have had an impact on women's health in the affected regions. According to Ityavyar and Ogba (1992), these conflicts lead to reduced spending on health care in favour of increased military spending. The authors add that violence leads to destruction of infrastructure such as hospitals, as well as exacerbating problems of hunger and malnutrition. Women and children are the most vulnerable in such situations.

A look at women's health and agricultural production in East Africa reveals trends with negative health implications for women. "New forms of agricultural production have altered the sexual division of labour. Many tasks undertaken by men in the past, such as clearing and digging, have become a responsibility of women in addition to their traditional tasks" (Raikes, 1989, p.450). Sub-Saharan African women generally experience increasing stress because of their overloaded work schedules (Smyke, 1991; Turshen, 1991). The increasing stress placed on women and particularly those in impoverished female headed households indicates a particularly crucial area of study where action could be taken to improve the health status of women and their families (Raikes, 1989). Like the women in other sub-Saharan countries, it is expected that Uganda's rural women experience increasing stress as a result of their heavy work load.

Women in developing countries are also exposed to occupational and environmental hazards. The Canadian Public Health Association (1992) identifies several of these hazards as vector-borne and water-borne diseases, deforestation, and use of wood fuel. The uninformed use of agricultural pesticides and fungicides by rural women in developing countries is another form of environmental hazard. Agricultural extension services in these countries are not sufficient to provide farmers with enough information about the safe use of the chemicals. Since women play a major role in agricultural production in these countries (Saito & Spurling, 1992), they are exposed to health risks related to these agricultural chemicals, such as cancer, miscarriages and birth defects. In the case of wood fuel, Ardayfio-Schandorf (1993) points out that throughout the African region, 90% of rural women use fuel wood, charcoal, agricultural waste, and cow dung for cooking (p. 380). The author reveals that wood smoke has been found to be injurious to women's health, as the women breath air heavily polluted with carbon monoxide, particulate, and hydro-carbon emissions. The same author quotes two studies that support his argument. One of the studies revealed that pregnant women who cooked over fuel wood stoves had an almost 50% greater chance of stillbirth, while the other study revealed that women who cooked with straw or fuel wood when they were 30 years old had an 80% greater chance of having lung cancer in later years (p. 381) than women who did not cook with straw or fuel wood when they were 30 years old. These are typical environmental hazards to which Ugandan rural women are exposed in their daily lives.

Breast and cervical cancers are leading causes of death in developing countries. "In most of sub-Saharan Africa, cancer of the cervix is at the top of all the cancers that affect women, with breast cancer not far below" (Okojie, 1994, p.1240). Ugandan women, especially in rural areas, are likely to be experiencing the same situation, given that the women do not have easy access to medical testing technology for early identification.

2.6. Existing gaps in women's health care research.

The perpetual health problems experienced by women (as discussed above), highlight the fact that women's health needs are not entirely the same as men's. It is therefore imperative to design services that are sensitive to the peculiarity of women's health needs. This calls for more research efforts on how to improve the quality of care for rural women. At the World Health Organisation Workshop held in 1994 in Hungary, a related concern was raised. The Workshop participants concluded that efforts to assess and improve the quality of health care for women are still in formative stages (Muecke, 1996, p. 389). Similarly, the definition and clarification of gaps in knowledge about the health and diseases of women of all ages was identified as the ultimate purpose of women's health research at the Second Meeting of National Leaders in Women's Health (Health Science Centre, 1997). So far, research on women's health is imbalanced because it emphasises women's reproductive functions over their productive functions (Eide & Steady, 1980; AbouZahr, Vlassoff & Kumar, 1996). AbouZahr et al (1996) further argue that research on women's health has not been sufficient because it rarely considers other aspects of reproductive health apart from Family Planning.

"World-wide, the norm is to provide health care without taking gender into account, yet health care is experienced differently by women and men" (Muecke, 1996, p. 385). Research efforts have also not been sensitive to gender. AbouZahr et al. (1996) point out that for the most part, the conceptual research work on quality of health care for women does not address gender relations among the population served or clinic staff, or between providers and clients. This highlights the need for a gender perspective in health care research.

2.7. Overview of theoretical orientation.

In view of the above, it may be inferred that there is need for a holistic and more analytical research approach. This would provide a clear understanding of Ugandan rural women's daily life conditions and health problems vis-à-vis their health services. It is expected that this would reveal the nature and relevance of the existing services, and how they can be improved. With regard to health care and promotion, there is need for an approach that would promote equity whereby the magnitude and urgency of the individuals' or population groups' health problems would determine the type, magnitude, and urgency of health services.

As my theoretical orientation, I use the gender perspective to critically analyse the nature, relevance and extent of the health care services for rural women in Uganda. Because of its recognition of gender as an important variable in determining population health, I consider the gender perspective as the most appropriate for this study. Muecke (1996) argues that unless the quality of health care for women is viewed from a gender perspective, it has little value and is inadequately known. This study is also theoretically based on the structural approach which recognises health as a function of not only medical care but also behavioural, and the socio-environmental variables. Under this approach, the focus would be on the improvement of medical care, encouraging health-enhancing change at individual/behavioural level, such as rural women abandoning the tendency to accept pain as part of their daily lives. The focus would also be on encouraging change at societal level, such as abandoning the culturally sanctioned negative perceptions on the use of Family Planning, economic empowerment of women, and increasing women's decision-making ability in the household. Thus, the structural approach considers that in order to achieve population health, variables such as medical care, individual behaviour, socio-cultural beliefs, and the physical environment, must be fully addressed. The approach also considers that the above variables interact in determining population health.

CHAPTER III: METHODOLOGY

3.1. Introduction.

As discussed later in this chapter, this study uses qualitative research methods to assess the quality of health care for Ugandan rural women. Data were collected from two rural communities of Kasana and Kasokwe Parishes in Mukono District, in the central region of Uganda. In both of the study sites, 80 rural women (40 from each study site), and 21 health care providers were interviewed. The data collection exercise took 11 weeks to complete.

3.2. Objectives of the study.

It has already been pointed out that the main objectives of this study were to: (a) provide a detailed picture of the health needs of Ugandan rural women; (b) identify the gaps in health service accessibility and delivery as perceived by rural women on the one hand, and health care providers on the other; and (c) recommend strategies to improve the health of Ugandan rural women. The realisation of the above objectives was an important consideration in determining the method choices below.

3.3. Method choices and rationale for choice taken.

Qualitative research methods were used to collect data for this study. According to Creswell (1998), one undertakes qualitative research in a natural setting where the researcher is an instrument of data collection who gathers words or pictures, analyses them inductively, focuses on the meanings of participants, and describes a process that is expressive and persuasive in language (p. 14). This study was undertaken in a natural setting as described above, where interviews were held with rural women without interfering with their daily lives. Marshall and Rossman (1995) give a justification for qualitative methods in cases where the research is exploratory or descriptive and that stresses the importance of context, setting and the participants' frame of reference (p. 44). In particular, the authors point out that qualitative methods are appropriate for research that delves in depth into complexities and processes. The methods are also appropriate for trying to understand where and why policy and local knowledge and practices are at odds (p. 43). This study examines the complexities and processes relating to Ugandan rural women's experiences with their health services. The study attempted to explore the congruence between the health policies as reflected in the services, and the views of the rural women in respect to their needs.

In particular, a grounded theory approach was used to collect data for this study. Grounded theory is a method developed by Glaser and Strauss in 1967 (Wuest, 1995). "A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon" (Strauss & Corbin, 1990, p. 23). Grounded theory method seeks to develop a theory "grounded" in data pertaining to actions, interactions and social process of people (Creswell, 1998). Thus, it was the most appropriate method for this study as the study focused on actions and interactions of women and health care providers, and how these affect the status of women's health as well as the quality of health care for the women. Grounded theory is based on the tenets of *symbolic interactionism* (Blumer, 1969). In this case the interest is to understand how individuals take and make meaning in interaction with others (Marshall & Rossman, 1995). Focus was on services offered to women by health care providers, and what the services mean to the providers on the one hand, and the recipients (women) on the other, in terms of relevance and sufficiency.

3.4. Research activities.

3.4.1. Research permission.

At the University of Alberta, this research project was reviewed and approved by the Human Ethics Review Committee of the Faculty of Agriculture, Forestry, and Home Economics before the commencement of the project. In Uganda, the Ministry of Health requires their consent for health research conducted in the country. Both the Ministry of Health headquarters and the Mukono District Medical Office (DMO) provided their consent for this research.

3.4.2. Interviewer selection.

The issue of women's health, especially their reproductive health, is sensitive, and it is likely that female participants would withhold information from a male interviewer. To avoid this problem, I hired female research assistants to conduct the interviews with the rural women. In addition, the interviews were semi-structured, thus the probing quality and consistency of the interview questions were very important to this study. In view of the above, two requirements were set as a condition for interviewer selection. The first was formal training in research methodology, particularly qualitative methods. The second was interviewing experience. Two research assistants were hired for the exercise. One of them was a graduate student in

Gender Studies at Makerere University, who had just completed data collection for her Master of Arts thesis work. The other assistant was a public health practitioner who held a Makerere University Diploma in Public Health. She had not only the necessary requirements but also community work skills through her work with World Vision, an international non-governmental organisation that runs community awareness and relief projects in rural areas.

3.4.3. Site selection.

3.4.3.1. District.

There were two considerations in selecting the district where the research would be carried out: (a) The district needed to have typical Ugandan rural settings that are usually characterised by; (i) manual agriculture on land that is basically owned by male heads of households, (ii) lack of, or inadequate supply of clean water, and (iii) inadequately developed infrastructure such as roads and health services. All these characteristics have health implications on women. This provided a wide range of choices as almost all of the districts in Uganda are basically rural; (b) The researcher needed facilities such as office space with electric power supply for regular data processing. These facilities are usually not available in the Ugandan rural areas where the data collection was to take place. It was therefore important that I select a district that would enable easy access to the above facilities.

Mukono District was selected since all the characteristics outlined above are evident in the district. In addition, the district is close to Kampala City where I resided and had access to electric power supply for my regular data processing.

3.4.3.2. Rural communities.

Having selected the district where the research would be conducted, the next step was to select two study sites within the district. One main consideration in selecting two sites was the need to collect a diverse range of views and perceptions from the women. It was expected that women in two rural communities that do not share the same health care facilities were likely to have different experiences with the health care system. Therefore, the selected rural communities would ideally have access to different health care facilities (except when referred to the district hospital). Thus, these communities had to be far apart. With the above criterion, I selected Kasana Parish in Nakifuma County and Kasokwe Parish in Bbale County. The distance between the two parishes is approximately 90 kilometres.

3.4.4. Preliminary exposure to study settings.

Prior to the data collection exercise, several visits were made to the study sites. During these visits, my research assistants and I had the opportunity to meet and discuss the project with the local administrators, the Local Council Executives. These administrators were very important because their consent was a prerequisite to gaining entry into the communities. In addition, the administrators are normally expected to possess records with names and particulars of all residents in their administrative units. However, the administrators told me these records were not available. As an alternative, the Secretaries for Women's Affairs in the local administration system compiled lists of women in the parishes. This was the most appropriate alternative because the Women Secretaries are, by the nature of their duties, expected to be in regular touch with all the women within their parishes. These Secretaries were able to visit all the households in the parishes to ensure that no women were left out of the lists. Compiling the sampling lists took one week in each of the study sites. I reviewed these lists and developed sample frames for the two study sites. Fowler (1993) defines the sample frame as "the set of people that has a chance to be selected, given the sampling approach that is chosen" (p. 10). This is further discussed in the sampling section.

Men were also important for this exercise because most ethnic groups culturally bar women and wives from direct access to strangers. Only those men who were spouses of women participants were contacted after drawing the samples of the women participants. It was expected that in this cultural setting, only spouses of the women participants needed to give the support necessary for the success of the exercise.

3.4.5. Sampling.

"For a grounded theory study, the investigator chooses participants based on their ability to contribute to an evolving theory" (Creswell, 1998, p.118). This is called theoretical sampling. Gall et al (1996) refer to this as *purposeful sampling* whereby the goal is to select cases that are likely to be information-rich with respect to the purpose of the study" (p. 218). Since this study is about the quality of health care for Ugandan rural women, the participants included the rural women who were expected to have broad knowledge about their own health problems and services. The other category of participants was that of health care providers whose views about the services they provide to the rural women were vital for the generation of this study's grounded theory.

3.4.5.1. Sampling of rural women.

The Secretaries for Women's Affairs on the Local Council Executives were helpful in compiling lists of all eligible women in their parishes. These Secretaries visited all the households in the parishes and recorded all women between 15 and 55 years of age and either with or without spouse. The age span excluded those outside the reproductive age, where the uniqueness of women's health problems is most experienced. Women still under parental control were eliminated because their health care needs were often provided for by their parents, and thus were not in a good position to assess the health care system. These lists formed the sample frames from which the samples of the two study sites were drawn.

The sampling was random, that is; "selecting a sample in such a way that each item or member of the population under study has an equal chance of being selected for the sample." (Gebremedhin & Tweeten, 1994, p. 54). Numbers corresponding with those assigned to the women on the sample frame were written on small separate pieces of paper which were folded and put in a basket. Then, one at a time, the papers were randomly picked and women with corresponding numbers formed the sample. The sampled women were eliminated to avoid being re-sampled.

As Morse (1986) and Sandelowski (1986) put it, the exact sample size necessary to adequately develop this study's grounded theory was impossible to know before commencing the exercise. This justified the need for an iterative process whereby sampling, data collection, and data analysis are done over and over again in order to build the theory from the data. Thus, the sampling was done repeatedly, followed by data collection and analysis. For each of the two study sites, 10 women were sampled at the beginning. These women were to form the focus group. This was followed by sampling for individual interviews.

After reviewing the individual interview notes and audiotapes, and revising my interview questions to focus on areas of greatest concern to the women, I drew another simple random sample from my sample frame which did not include the women who had been selected before. This sampling process was repeated three times in each of the study sites. Each time, an average of fifteen women were sampled. Out of a total sample of 140 women, 17 women (9 from Kasana Parish, and 8 from Kasokwe Parish) were available for focus group discussions, while 63 women (31 from Kasana Parish, and 32 from Kasokwe Parish) were available for individual interviews. In total, 80 rural women were interviewed.

3.4.5.2. Sampling of health care providers.

The health care staff who provided the services to women in the study sites were automatically selected to participate in this study. In particular, the participants included: (a) Service providers at health units most accessible to women in the study sites; (b) Service providers at health centres and dispensaries accessible to not only the women in the study site (parish) but also those women in the neighbouring parishes; and (c) Service providers at district referral hospitals including private hospitals such as those run by Catholic missions. From the above, it will be noted that the participants were carefully selected with the assumption that the health care providers at different levels within the same system did not necessarily have the same views and experiences relating to the rural women. Of special interest were staff members of Family Planning, Maternity, and Safe Motherhood (antenatal and postnatal) Clinics.

3.4.6. Research procedures.

3.4.6.1. Overview of grounded theory data collection and analysis.

Grounded theory methodology provides that data analysis occurs concurrently with data collection and the specific focus or research question emerges as the analysis proceeds (Glaser & Strauss, 1967; Hutchinson, 1986). Data for this study were collected using in-depth semi-structured interviews with rural women and health care providers (see appendix C for the guiding questions that were used for each of the two categories of participants). Several questions were open-ended in order not to limit rural women's views that may have been unanticipated by the researcher (Field & Morse, 1985). Apart from interviews, other sources of data included field notes from observations and relevant health care documents such as the Ministry of Health's *Procedure Manual for Family Planning and Maternal Health Service Delivery* (MOH & INTRAH, 1995).

3.4.6.2. Interviews with rural women.

Given the cultural constraints imposed on Ugandan women as they relate with strangers, it was vital that the interviews be held in an atmosphere that encouraged free flow of information. With this in mind each participant was asked to choose the location that she considered suitable for her. This enabled the women to share their experiences with minimum inhibition. Before commencement of each interview, a translated copy of the study's Information Sheet (see Appendix A) was read to each participant. All rural women participants were reluctant to sign the Informed Consent Forms (see Appendix B). Instead, the participants preferred verbal consent and this was audiotaped for record-keeping purposes. In both study sites, there were no cases where a woman refused to participate in this study.

In each of the study sites, individual interviews were preceded by one focus group discussion with rural women. As suggested by Marshall and Rossman (1995, p. 84), the purpose of these focus groups was to explore general topics and other unanticipated issues as they arose in the discussion. To promote rigor in these focus group interviews, I emphasised to my research assistants the need to do more listening than talking, encourage all participants to talk and to guard against members who may dominate the conversation. In addition, these discussions were audiotaped.

The Secretaries for Women's affairs helped locate and organise the women for the focus group discussions. In Kasana Parish, 9 women attended the discussions, while in Kasokwe Parish, 8 women attended. This was in line with Stewart and Shamdasani's (1990) suggestion that membership of a focus group ranges from 8 to 12 individuals. The women that did not attend the discussions were either too busy or had patients to attend to. These women were not added to the potential interview list. The focus group discussions gave the rural women a chance to brainstorm on the major research question, that is; what is the quality of their health care services in terms of relevance and sufficiency, and how can the services be improved? The views and concerns of the focus group participants formed a basis for the individual interview questions.

The focus group discussions were then followed by individual interviews with the rural women. On the average these interviews lasted 45 minutes. It should be noted that all the interviews with the rural women were conducted by research assistants. In this case audiotaping was most important as it provided an opportunity for me to re-play the interviews and therefore assess the performance of the assistants, especially their probing skills. The research assistants conducted the interviews in the local dialect (Luganda) and took notes in English. Comparing the audiotaped interviews with the interview notes also helped me to assess the assistants and to suggest improvements where necessary.

3.4.6.3. Interviews with health care providers.

I conducted the interviews with health care providers. As was the case with rural women these interviews were audio-taped. It will be noted that in the case of health care providers I identified two categories; (a) those staff whose duties were more of administrative than health care provision, and (b) those directly involved in providing services to the rural women. Only those staff directly involved in providing services were considered for interviews as they were the ones expected to have practical experiences with the rural women clients.

Both focus group and individual interviews were held with the health care staff. Individual interviews were common with staff at the lower levels of the health care system. This was because some of these units were staffed by a single staff member who was both the administrator and the service provider. In addition, this staff member attempted to provide a variety of services ranging from general practice to specialised services such as family planning. In Kasana study area, I held individual interviews at Womeraka Clinic and the Nakifuma Health Centre. In Kasokwe study area, I held individual interviews at Kasokwe Aidpost and Bbale Health Centre. I held one other individual interview at Kayunga hospital.

Focus group interviews were held with staff at higher levels of the health care system. Such levels were characterised with bigger numbers of staff who provided a variety of specialised services in a semi-autonomous environment. In such situations, I had two options: (a) To conduct individual interviews with staff from different sections within the health unit. This option was costly both in terms of time and money as I had to make multiple visits to the same health unit; and (b) To conduct focus group interviews whose members comprised of staff from a variety of specialised services for women. This option was preferred for its cost-effectiveness, as it would enable me to collect the required information from the health care providers within a shorter time. I held focus group discussions at Nagalama Hospital in Kasana study area, and Kayunga hospital. In these focus groups, staff from Family Planning, Maternity, and Safe Motherhood services were represented.

In each of the study sites interviews with health care providers were conducted at the conclusion of the interviews with rural women. This was in line with grounded theory's practice whereby the research exercise begins with studying a homogenous sample of individuals (rural women in this case), and then after developing the theory, studying a heterogeneous sample which, in this case, comprised of the health care providers (Creswell, 1998, p. 118-119). The rationale for starting with a homogeneous group is to minimise differences among the participants in order to verify the relevance of the emerging categories and their properties. On the other hand, Creswell (1998) adds that the rationale for studying the heterogeneous sample is to confirm or disconfirm the conditions, both contextual and intervening, under which the model holds. Conrad (1978); and Strauss and Corbin (1990) argue that maximising differences in data once the focal aspects are identified enables further generation and refinement of the theoretical properties of the research.

As noted earlier, I assumed that health care providers at different levels within the same system had different views and experiences with rural women clients. Therefore the selection of the health facilities whose staff were interviewed was done in such a way as to include one health facility at each level of the district health care system. The interviews always started at the lowest level of the health care system (grassroots level) up to the district health care facilities. At each level a single health facility was selected for the interviews. In Nakifuma County where one of the study sites (Kasana Parish) is located, health care providers at Womeraka Clinic, Nakifuma Health Centre, and Nagalama Hospital were interviewed. In Bbale County where the other study site (Kasawo Parish) is located, health care providers at Kasawo Health Unit and Bbale Health Centre were interviewed. This was then followed by interviews with health care providers at Kayunga hospital.

3.4.6.4. Data Analysis.

As in other grounded theory studies, the *constant comparative* method was used to analyse data. Creswell (1998) refers to this as "the process of taking information from data collection and comparing it to emerging categories" (p. 57). This process continued throughout the data collection exercise.

Following each day of fieldwork, the research assistant handed over to me interview material comprising of interview notes, interview audiotapes and the recorder. Because of time and resource constraints, the tape-recorded interviews were not transcribed. This was more so because the interviews had to be translated into English. Instead, the interview notes relating to specific participants were assigned numbers that corresponded with their tape-recorded versions. This enabled me to peruse the interview notes relating to each participant and immediately after, listen to their respective tape-recorded version. I listened to the tapes more than once to ensure that no categories or other components of the data were left out during the coding process. Whenever I discovered omissions by the assistant, I added these as new meaning units or categories on the coding sheet. With numbers assigned to my interview notes and their audiotaped versions, I was able to keep track of all the women participants to which a common category/subcategory was attributed. I did this by checking the numbers against the categories/subcategories attributable to the respective participants, on the coding sheets. This enabled me to refer to all those interviews where a specific category/subcategory was raised, in order to put all of the women's views in perspective.

The process of data analysis was characterised by a systematic coding format beginning with open coding where I broke down the data to form initial categories of information about the phenomenon being studied. A category represents a unit of information composed of events, happenings, and instances (Strauss & Corbin, 1990). For instance, the statement by a woman participant such as "I need Family Planning services but I do not have the money to visit the clinic regularly as required by the service providers" featured "use of Family Planning services" as a category. Within each category, several properties, that is, attributes or characteristics pertaining to a category (Creswell, 1998) were identified. For instance, after examining the participant's statement above, three properties or meaning units were identified; (a) need for Family Planning services, (b) lack of money, and (c) physical inaccessibility. These were grouped under the category, 'use of Family Planning services'. Data from different participants were closely examined and compared for similarities and differences, and the emerging questions and concepts determined the information to be sought in the subsequent interviews. This was in line with the constant comparative method of data analysis. This process went on as new data were collected from the field.

The next stage was axial coding where I assembled the data in new ways and the central phenomena (central categories about the phenomenon) were identified. For instance, at this point data were regrouped into three central categories; a) rural women's health experiences, b) rural women's experiences with the health care services, and c) rural women's recommendations for change to the health care delivery system. Thus, a category such as "use of Family Planning services" that was identified during the open coding stage was at this point subsumed as one of the various subcategories under the new category; "rural women's experiences with the health care services". Causal conditions (categories of conditions that influence the phenomenon) were then explored and strategies (actions or interactions that result from the central phenomenon) were specified.

The last stage was selective coding where I integrated the categories along a dimensional level to form a theory. I explored relationships among categories and identified any categories that needed further development. The above process was characterised with linking and further reduction of categories. At this point, the reduction of categories was apparently aimed at the ultimate category, namely; the quality of health care services. Theoretical codes as spelt out by Glaser (1978) were established to help in organising and explaining the relationships among the categories. The author refers to these codes as the "six C's: causes, contexts, contingencies, consequences, covariances, and conditions" (p. 74). The process of constant comparison helped in the discovery of core categories and variables that were vital in building the grounded theory from the data. As Hutchinson (1986) put it, the core categories or variables were identified by their ability to recur frequently in the data; link the various data together; and explain much of the variation in the data.

3.4.6.5. Trustworthiness.

In addressing the issue of trustworthiness, the major question is "how can an inquirer persuade his or her audience (including self) that the findings of an inquiry are worth paying attention to, worth taking account of" (Lincoln & Guba, 1985, p. 290)? Sandelowski's (1986) categorisation of trustworthiness includes; truth value (credibility), applicability (fittingness), consistency (auditability), and neutrality (confirmability).

As the interviews with rural women were conducted by the research assistants, measures had to be taken to ensure that the assistants do not misrepresent the views of the participants. This was intended to promote the truth value (credibility) of the findings. In this case, the audiotaping of the interviews was considered a useful aide, as the interviewer's notes would be closely compared with the audiotaped version to confirm that the notes reflected the participant's views. In relation to this, since it became apparent that the interviewer's notes were often not exhaustive of the views of the participants, audiotaping served to fill the gaps, given that it was a complete representation of the story as it unfolded.

Applicability (fittingness) of the findings was considered equally vital for this project. In order to ensure that the findings were applicable to the population being studied, participants were selected on the basis of their ability to assess and describe the health care services for Ugandan rural women. By way of theoretical sampling (already discussed), samples representing a diverse range of rural women and health care providers were drawn. These samples were drawn and interviews conducted in typically rural study sites where the Ugandan rural women live. Thus, one might expect the findings to be applicable to the rural women.

Consistency (auditability) was also observed. Sandelowski (1986) outlines several steps in achieving auditability: how the researcher viewed the studied phenomenon; purpose of the study; how participants were included in the study and how they were approached; the impact that the participants and the researcher had on each other; how the data were collected; length of data collection; data collection settings; how data were transformed for analysis, interpretation, and presentation; how various elements of the data were weighted; the inclusiveness and exclusiveness of data categories; and techniques used to determine the truth value and applicability of the data. This thesis addresses all the above steps.

Confirmability (neutrality) is important in qualitative research where the researcher is an instrument of data collection and analysis. This raises the issue of subjectivity on the part of the researcher. Confirmability was observed in a sense that I was conscious about my preconceived biases and expectations and always endeavoured to put these aside as I tried to make sense of the data.

3.5. Strengths and weaknesses.

One major strength of this study is that I am Ugandan, thus I have rich experience and knowledge of the general socio-economic and health conditions pertaining to women in various regions of Uganda. Therefore, my choice of the two study sites in Mukono district was a result of my feeling that these sites would fairly represent the general conditions experienced by women in the country. Besides, my knowledge of the local dialect (Luganda) enabled me to minimise data loss during the process of translation of the interview audiotapes from Luganda to English. I was also able to effectively assess my research assistants who interviewed the rural women in

Luganda and made interview notes in English.

Weaknesses of this study relate to the research site, time, and methods. In spite of the major strength mentioned above, there could still be some problems with the generalisability of the study findings. This is because Uganda has over 30 districts and it is possible that women in different districts might have unique health problems and experiences with the health care system. However, the general socio-economic and health conditions such as poor health and inadequate distribution of health care services are similar across the country. Thus, the findings can still be considered to be generalisable to all districts in Uganda.

Another weakness was related to time. The data collection exercise took 11 weeks yet more time may have enabled the discovery of more issues of concern to women. However, even with the available time, it was felt that all the information categories were saturated when the participants started repeating the issues already mentioned.

Employing research assistants to conduct the interviews with the rural women entailed some weakness. This is in a sense that in spite of the rigorous training the assistants underwent, they could not exhaustively interview the participants the way I, the initiator of the project, would have done. For instance, as I perused the interview notes, I discovered some issues on which I felt that more probing was needed. However, I addressed this problem by reviewing the audiotapes after perusing the notes and then immediately discussed with the assistants how to improve their interviewing skills.

CHAPTER IV: FINDINGS

4.1. Introduction.

As stated in the literature review chapter, the health of women especially in rural areas of developing countries has continued to be poor, in spite of the presence of a variety of health care services in these countries. This is the case with Uganda where rural women suffer from a wide range of health problems. In the same chapter, it was also observed that women's views and perspectives as recipients of the services have traditionally not been considered in designing health care programs in these countries. This study was prompted by the desire to ascertain the major health concerns of the women from the women's own point of view.

The findings of this study reflect Ugandan rural women's perspectives on the health concerns of the rural women, the available health care services, and recommendations for change to the health care system. The data collected from health care providers were only used for further generation and refinement of the theory (Conrad, 1978; Strauss & Corbin, 1990) that had already been developed from interviews with rural women.

These findings are presented in detail under three broad categories, namely; *rural women's health experiences, rural women's experiences with health care services, and rural women's recommendations for change to the health care services.* This is followed by a presentation of health care providers' perspectives on the issues of concern to the rural women participants. Quotations of participants' own statements from the audiotaped interviews are cited throughout this presentation to illustrate the grounded nature of this theory. However, this was done without losing sight of the already existing knowledge and literature that is related to this area of study.

4.2. Context, Conditions, and Strategies.

In order for the reader to gain a better understanding of the findings, I begin with a presentation of the context and conditions within which the rural women live, and the strategies adopted by the women. This is based on the revelations of women participants.

4.2.1. Context.

It is important to emphasise that health is determined by not only the quality of health care services but also other factors such as the socio-cultural and economic settings of a given society. I considered these settings to be the context, in which the rural women live and work.

4.2.1.1. Socio-cultural setting.

In the study area, like in other districts of Uganda, different standards are used when assessing the health status of men and women. As Raikes (1992) argues, the threshold of illness recognised by society on the illness-health continuum is so high for women in these areas that they endure pain in their daily lives. The situation is reflected in the participants' own statements such as:

> *The doctor diagnosed me with syphilis. I also have a heart problem. Yet my husband has not allowed me to go for treatment (participant # 32).*
>
> *I'm feeling sickly. My health has not been good since 1994....I have to walk a long distance to fetch water for domestic purposes (participant # 39).*
>
> *Even when I'm sick, I'm expected to prepare food for the family. So I can only*

> *get time [to seek health care] after cooking (participant # 59).*

Besides, social norms in this area are that women are submissive to men, and consequently, the women are subjected to numerous controls. This explains why many women cannot make any major decisions without the consent of their male guardians or spouses. During the interviews, many rural women participants disclosed that their spouses would not allow them to take actions that would help improve their health and general wellbeing.

> *I wanted to join the Family Planning program but my husband refused me....I now have eight children....I have a painful abdomen, I think it is my uterus that has a problem (participant # 5).*
>
> *We are not allowed by our husbands to join Family Planning programs because of the social belief that Family Planning is for prostitutes (focus group participant).*
>
> *As women, we are downtrodden and often intimidated by men. We cannot raise any issues against the men or for the benefit of ourselves in the Local Council meetings. This makes our problems persistent since they are not addressed by any formal institution (focus group participant).*
>
> *Our husbands do not allow us to attend any educative workshops or seminars that are sometimes brought to this area. This is because of the social belief that educated women are not easily controlled (focus group participant).*

These and many other revelations by the women participants illustrate the unfair restrictions society imposes on women, and the potentially negative impact these restrictions have on the health and general wellbeing of the women.

4.2.1.2. Economic setting.

Culturally, women do not have direct access to the means of production such as land. They only access land through their male guardians, their male children or their spouses. In spite of this, it is the women who do the bulk of the agricultural work in these countries (Saito & Spurling, 1992) as well as other forms of economic activities. Many rural women participants disclosed that they are the sole contributors to the economic sustenance of their families.

> *I have to work, dig.... which is tiresome and makes me weak. I have no alternative because I have a big family that depends on my economic support (participant # 1).*
>
> *My husband has so many children from other women. Therefore, he cannot take care of all of them. The burden is on us mothers (participant # 6).*
>
> *Men no longer look after women and children. Therefore, we as women have to do petty business to look after ourselves, our children and meet their scholastic needs (participant # 31).*

This situation has served to worsen the economic and health status of the women as they have to work strenuously to sustain their families.

4.2.2. Conditions.

I considered the causal conditions to be those factors that negatively interfere with the rural women's health seeking abilities when they are sick and in need of health care. These basically include physical accessibility/distance to the health care facilities, money, and time. These factors were considered to be causal conditions because they cause women not to seek care when they need it, which in turn causes poor health.

4.2.2.1. Physical accessibility and money.

Physical accessibility (distance) and money are interrelated because many rural women participants concurrently pointed out the two as they described the difficulties that they encounter while seeking health care services. According to both the rural women and health care providers, the facilities that are most accessible to the rural communities do not have laboratories and they usually lack most of the required drugs. In addition, the facilities only have some but not all of the professionals that would offer the highly needed specialised services such as Family Planning, Sexually Transmitted Disease (STD) Clinics, Antenatal and Postnatal Clinics, and Maternity Clinics. This means that the rural women have to travel longer distances to access the above services. Most often the women do not go for such services because the services are far and they usually do not have the money both for transport and treatment.

> *We have a problem of transport as some of the services we need are far away. It is unaffordable for us because we are poor. That is why we rarely go for treatment when we are in need of services that are not available in the nearest health facilities (participant # 6).*
>
> *I have recurrent abdominal pains on one side of my body. I need to go for an X-ray examination to know what is wrong, but such facilities are far away and yet I do not have the money for transport and the examination itself (participant # 38).*
>
> *We do not have maternity clinics that would handle complicated delivery cases. Women in such situations have to be transported to distant clinics.... and the basic means of transport from our village to the main road are motor-cycles. These motorcycles are uncomfortable for pregnant women (focus group participant).*
>
> *I think I lost my babies because the clinic was far away and the motorcycle was uncomfortable (participant # 14).*

I also found out that lack of money could (among other reasons) explain the possible problem of drug-resistance as suggested by the fact that many women participants reported recurrent health problems. The statement below was echoed by many women participants.

> *I was satisfied with the treatment that I received at the clinic but I failed to get the money to make a follow-up visit as advised by the health care provider. So I never went back (participant # 57).*

The above situation is worsened by the fact that some of the hospitals that should ideally have almost all of the services do not in fact have some of the highly needed services. This is the case with Nagalama Hospital, which does not have a Sexually Transmitted Disease (STD) Clinic. The same hospital does not provide Family Planning services because, as the hospital staff members revealed, it is a Catholic mission hospital and Catholicism does not sanction the use of such services.

4.2.2.2. Time.

Time was found to be another factor that influenced rural women's ability to seek health care. The women participants disclosed that they hardly had the time to seek health care services in spite of the fact that many of them were in need of the services. In some cases the women lacked the time to make the required follow-up visits, while in other cases they could not make even the first visit to a health care facility.

> *I had pain in my arms and even got paralysis. I went to the clinic and the doctor advised that it was syphilis.... but I could not finish all the prescribed injections because of the work at home. I also seriously needed to join the Family Planning program but because of time constraints, I delayed and now I'm pregnant, yet I already have many children (participant # 26).*

Similar sentiments were echoed by many women participants as they described the difficulties that they encounter when they are in need of health care.

4.2.3. Strategies.

In view of the above context and conditions the rural women have over time developed coping strategies to deal with their difficulties. These strategies include ignoring the sickness, self-medication, use of herbal/traditional medicine, and secret use of Family Planning services.

4.2.3.1. Ignoring sickness.

Many women participants disclosed that they often ignore their health problems hoping that the problems would go away on their own. The women added that usually they are forced to seek health care when the sickness becomes serious.

> *Most times when we are sick we leave the disease to heal by itself through natural ways (participant # 9).*
>
> *Because of the money limitation, I never seek health care until I become extremely sick (participant # 36).*
>
> *I do not go promptly for health care because sometimes I think the sickness will go away on its own (participant # 37).*
>
> *When I develop a health problem I take about a year before reporting the problem to a health care centre, as I have to look for money (participant # 38).*

4.2.3.2. Self-care/medication.

Self-care/medication was found to be another popular strategy by the women participants. Women (sometimes with the help of their spouses) form opinions of what they are suffering from, and decide to purchase the type of drug that they deem appropriate, given the limited amount of money available. Self-medication is done even in cases where the women suspect STD's and other complicated cases such as kidney problems.

> *I suffered from persistent joint pains until my husband bought me medicine for syphilis. Now I'm better (participant # 40).*
>
> *I usually do self-medication on myself. For example I have a kidney problem and whenever I feel the pain I buy my own drugs from a drug store (participant # 38).*

Given that some of the symptoms the women experience are common with a number of health problems, there appears to be a high probability of wrong diagnosis, and thus, wrong treatment when women self-medicate.

4.2.3.3. Herbal/Traditional medicine.

Several women participants disclosed that they were using herbal or traditional medicine because they could not financially afford modern medicine. In addition, I later found out that the loss of confidence in the efficacy of modern drugs was one of the main reasons why several women were resorting to this strategy. Statements similar to the ones below were echoed by several other women.

> *During pregnancy, I used to have pain in my abdomen. The medication I was given at the clinic did not help because the problem persisted. I had to resort to traditional medicine, which helped (participant # 24).*
>
> *Before I stopped producing children, I used to spend sleepless nights trying to comfort my sick babies. This happened to all of my four children. I took them to various hospitals and their health problems persisted. I then resorted to the use of traditional medicine which helped greatly (participant # 28).*

4.2.3.4. Secret use of Family Planning services.

Some women participants disclosed that they were using Family Planning services secretly because their spouses were strongly opposed to the practice. The women argued that they already had many children and they felt weak.

> *We are on Family Planning programs secretly because our spouses won't*

> *allow us.... Sometimes they tell us that the bible does not sanction the practice.... but we seriously need the service (focus group participant).*
>
> *I joined the Family Planning program without the knowledge of my husband because at one time I delivered twice in a year and I was feeling weak (participant # 45).*

Several other women participants who had not resorted to this practice expressed their intention to do so.

With the understanding of the context and conditions in the rural areas, as well as the women's coping strategies, I hope that the reader will appreciate the rural women's perspectives on their health, health care, and recommendations as presented below.

4.3. Rural women's health experiences.

4.3.1. Health problems as reported by rural women.

A summary of the health problems as reported by the rural women participants is presented in Table 1 below. It will be noted from the table that this particular data were collected from only 63 rural women participants who were interviewed individually. The focus group participants did not discuss their individual health problems since their discussions were restricted to the general health issues and problems pertaining to rural women in their areas.

It is also worth noting that the diagnosis of Sexually Transmitted Diseases (STD's) in rural areas is generally done on the basis of written guidelines (see appendix D for samples of the written guidelines). Therefore, the absence from the table, of other important STD's such as Genital Warts, Genital Herpes, Chlamydia,

Table 1: A range of health problems as reported by the rural women in the study sites, by order of importance.

POSITION	HEALTH PROBLEM	TOTAL COUNT OUT OF 63 WOMEN
1	Syphilis	30
2	Abdominal pains	14
3	Itching/sores in genital area	13
4	Malaria/Fever	12
4	Headache	12
5	Respiratory health problems	9
6	Recurrent body weakness	7
6	Heart Problems	7
7	Gonorrhoea	6
8	Swollen legs/pain/paralysis	5
8	Backache	5
8	Miscarriage/Birth complications	5
9	Uterus/cervical problems	4
9	Breast pains/lump/itching	4
9	Stomach ulcers	4
9	Colds	4
10	Over-bleeding during periods	2
10	Eye problems	2
10	Itchy skin/rash	2
10	Diarrhoea	2
10	Joint pains	2
11	Kidney problems	1
11	Asthma	1
11	Ear problems	1

should not necessarily suggest that the diseases are not prevalent in these communities. Rather, the lack of medical laboratory technology to diagnose STD's could explain the absence of the diseases, as there is lack of diagnostic precision.

As the table shows, syphilis was the most frequently reported health problem. Almost one in every two rural women participants reported that they are suffering from the disease, or that they suffered from it but are not sure whether they had recovered completely because they could not take confirmatory laboratory tests. Second on the list is abdominal pain which accounted for approximately one in every four women participants. This is followed by itching/sores in the genital area, which accounted for approximately one in every five women participants. It will be observed from the list that the top three health problems are all related to women's reproductive health.

Other health problems following the top three are malaria/fever, headache, respiratory health problems, recurrent body weakness, heart problems, and gonorrhoea. The table also shows several other health problems experienced by the women, notably uterus/cervical problems, and breast pains/lump/itching. At the bottom of the list are ear problems, asthma, and kidney problems.

4.3.1.1. Sexually Transmitted Diseases (STD's).

As the table above suggests, STD's are perceived by the rural women to be the most important health problems, with syphilis as the most commonly reported. From the interviews with both rural women and health care providers, it was apparent that men/spouses contribute significantly to the spread of STD's and their treatment failures. Two reasons were given to explain this phenomenon. The first reason is that many men have multiple partners, thus, a single man would likely spread the disease to all of his partners.

> *The men.... sleep with other women and get the disease which is then passed on to their wives. Most men do not allow us [wives] to go to the clinics and this leaves us helpless and we end up spreading the diseases to our children. In the case of Acquired Immune Deficiency Syndrome [AIDS].... when the men acquire the disease, they go for treatment early without notifying their wives. By the time the wife realises that the man is sick, it's too late (focus group participant).*
>
> *My body is not healthy, I feel pains off and on. At times I think that I have AIDS because my husband has lots of women partners (participant # 43).*

The second reason why men are considered a major factor in the spread of STD's is that they frequently do not give their spouses money or permission to seek treatment, and/or they do not seek treatment for themselves.

> *My husband may refuse to give me money for treatment and I feel embarrassed to keep going to a health facility without money (participant # 44).*
>
> *I have syphilis.... the health worker told me to go for treatment with my husband but my husband has not yet agreed to go for the treatment (participant # 45).*

In the case of syphilis, many of the women participants who disclosed having suffered or that they are suffering from the disease complained that the disease is recurrent after it failed to respond to various drug regimes. As a result, there is a misconception among several rural women that syphilis is incurable. Some of the women participants revealed that they are reluctant to seek treatment because they think it is a waste of time since they would not get cured. Thus, as a coping strategy the women are accepting the disease as part of their life.

> *I have syphilis. I have taken it to the doctor but as you know, syphilis does not get cured (participant # 28).*

> *I suffer from syphilis and though you treat it you never get healed. It is a waste of money, but when the itching and sores increase you just have no option but to go to the clinic (participant # 30).*

The above misconception seems to be reinforced by the unprofessional advice given by some health care providers. Some women participants revealed that they were told by some clinic staff members that the disease is incurable.

> *I have syphilis. They told us at the clinic that the disease cannot be cured, and that they give us medicine to just cool down the itching and pain (participant # 9).*

4.3.1.2. Human Immuno-deficiency Virus (HIV) and AIDS.

Because of the social stigma that is still associated with HIV/AIDS especially in rural areas, the women participants seemed not to be free to discuss their personal experiences about the disease. This, together with the general lack of laboratory testing services, might have shrouded important information about the disease. Nevertheless, the women revealed that the disease is a matter of serious concern and a few participants admitted having lost relatives to AIDS.

> *There is a major issue of AIDS.... and this has left many children parentless (focus group participant).*

> *My married daughter was brought back to my home when she was very sick with AIDS. Her elder sister died of the same disease and now I have to look after her children even without any source of income (participant # 13).*

4.3.1.3. Stress.

Compared to the other health problems that were disclosed by the women participants, stress is more difficult to identify because it does not manifest physically.

This is more so for persons who do not have the relevant medical training. However, I still consider it fair to say that stress appears to be widespread among rural women. In response to the question; "what are the general issues/problems, if any, that trouble you in your daily life?", a majority of the women participants revealed that they are very disturbed by the numerous problems that they experience in their daily lives. Many of the women pointed out financial problems as the major reason since according to them, they are the main breadwinners of their families. Women's daily chores and excessive childbearing are some of the other problems that were mentioned. In the statements below, the words that were used to respond to the above question might support the view that the problem of stress is real among the women. These sentiments were echoed by many women participants.

> *The man does not take care of my children and me.... I'm so disgusted with child-bearing....that is why I decided to go for Family Planning. Besides, I have to walk a long distance to collect water, there is no money to buy food.... (participant # 40).*
>
> *I have no peace with my husband and myself. My husband does not care for me at all, I take care of all the children's dressings.... (participant # 43).*

4.3.1.4. Cancers of the breast and cervix, and level of awareness.

Although none of the women participants disclosed having suffered from breast or cervical cancer, some of the women reported breast pain, lump, or itching. Others reported pains and other complications with their uterus and cervix. As table 1 shows, four women participants reported problems with their breasts while four others reported problems with their uterus and cervix.

My breast pains me severely.... The pain is persistent when I'm breast-feeding

> *(participant # 10).*
>
> *I have pain in my breasts but I have never sought treatment because the pain subsides by itself and resumes later (participant # 19).*
>
> *I always fear that I might have cervical cancer because my uterus [cervical area] and lower abdomen are very sore (participant # 13).*
>
> *I feel sickly most of the time. I have low abdominal pains and often feel like my uterus is prolapsing (participant # 35).*

From the interviews with the women participants, I found out that there is general lack of awareness about both breast and cervical cancers. Some women participants had heard of both cancers but were not necessarily aware about the cancers because they lacked the basic knowledge about them. Some of the women disclosed that they had heard of one but not both of the cancers, while others had never heard of either of the two cancers.

According to revelations by the women participants, there is slightly more knowledge of the existence of breast cancer than cervical cancer. As many participants disclosed:

> *I have heard people talk about cancer of the breast but not that of the cervix (participant # 35).*

However, even with more knowledge of the existence of breast cancer, none of the women knew how to perform a Breast Self-Examination (BSE). Only one woman participant disclosed having had a breast examination performed by a health care provider during her antenatal visits. In the case of cervical cancer, all of the women participants neither had had a check-up (Pap smear test) nor knew of any health facilities that offered such services.

For both cancers, the Ministry of Health has not yet engaged in any organised breast and cervical cancer sensitisation effort mainly targeted at the rural women. Because of this, several women participants reasoned that it was not necessary to take tests for either of the two cancers.

> *I do not need any cancer examination since I do not have that disease (participant # 38).*
>
> *I have not bothered to test for either of the two cancers because I have not received a proper explanation about them (participant # 47).*
>
> *I have never been examined for either of the cancers. How do I get examined when I'm not sick? (participant # 56).*

The above statements by the women participants demonstrate the fact that the women still view health care only in terms of treatment, and not prevention or early detection of health problems.

4.3.1.5. Violence Against Women (VAW).

The available literature indicates that violence against women plays an important role in women's mental and physical health (Smyke, 1991; Gerbert et al., 1996) especially in developing countries. However, VAW did not appear to be an important issue to the women in this study. Many of the rural women participants acknowledged having been physically or verbally abused by their spouses, but this problem did not seem to concern the women. The lack of concern among the women is demonstrated in statements below, which were echoed by several women.

> *My husband sometimes beats me, but it is usually when I have either delayed to serve food, or gone away from home without his consent (participant # 5).*
>
> *If you have a home and you are married, you have to bear problems of being*

beaten or looked down upon by your husband (participant # 17).

The implication of the above statements is that VAW is acknowledged by the women as a normal occurrence, and that they have resigned themselves to the inevitability of spouses' inclinations to use violence as part of their roles and rights.

4.4. Rural women's experiences with health care services.

In the presentation below, I identify only those specific cases that might provide some useful insights into the deficiencies in quality and quantity of the present health care services. The presentation is not intended to portray the health care system as having nothing to offer. In fact, I observed some positive effort that had been made by the Ministry of Health to improve the available services.

4.4.1. Satisfaction with services.

The majority of women participants disclosed that they are not satisfied with the services that they are receiving. For instance, several women participants are not aware of the presence of Community Health Workers (CHW's) in their community. Those women that are aware of the CHW's are dissatisfied with them because the CHW's usually lack the required drugs. The women also disclosed that the CHW's are not always available when their services are required, which suggested a need for the deployment of more workers.

> *We have one health worker and when she is away there is no one to take care of us (participant # 40).*

In regard to the rural clinics, the women mentioned that health care providers are not always available at their units, which suggested a problem of understaffing in these rural facilities.

> *I was not satisfied with the last visit to the clinic. I was requested to come again but when I came, I did not find any health worker around.... (participant #45).*

Many other participants consistently mentioned that they are not satisfied because the services they needed most, such as well-equipped STD and maternity health clinics, are generally inaccessible to them.

4.4.2. Provider-Client feedback.

Throughout the interviews, women participants occasionally used the phrase; *"I do not know what the doctor diagnosed me with"*. This suggests that health care providers do not always reveal all of their findings to the women clients. For instance, one woman revealed that she had a lump in her breast, which was surgically removed. However, she had no idea what brought the lump because she was not given an explanation by the doctor. When the woman was asked about cancers of the breast and cervix:

> *I have heard about cancers of the breast and cervix, but have never suffered from either of the two.*

After probing about how her breasts felt:

> *Five years back, I had a lump in my breast but it was removed. Now I'm ok (participant # 22).*

It is possible that the woman experienced preliminary stages of breast cancer, but because she was not fully informed, she could not monitor herself/be monitored for a possible relapse.

In the case of STD's, some women participants disclosed that after examinations they were given prescriptions and asked to purchase the drugs without being told what they were suffering from.

> *I guess I had syphilis. They took blood from me when I was pregnant and I guess they treated me for syphilis (participant # 39).*

This might partly explain why the woman did not go for a post-test because after she had had the laboratory test she was given no reason to suspect that a recurrence was possible.

4.4.3. Patient referral.

Several women participants revealed health problems that are either recurrent or serious enough to warrant referral for better quality care. However, some health care providers continued to advise patients in such situations, even when their advice was no longer helpful. For instance, one participant disclosed having severe breast pain especially during breast-feeding but the health care providers continued to prescribe painkillers without referring her to more advanced health care centres to test for breast cancer. The same participant disclosed that she had two miscarriages, yet different providers consistently did not refer her to clinics with more sophisticated facilities.

> *I have had two miscarriages and now I fear pregnancy. The doctors could not explain why. It just happens (participant # 10).*

4.4.4. Drug hawking.

In addition to the mainstream health care services that are provided by the Ministry of Health and organised private practitioners, the rural women disclosed that some individuals occasionally make house to house visits in these communities, selling drugs. These drug hawkers, commonly known as "doctors", can be categorised as informal health caregivers. According to the women, these drug hawkers sell drugs for a wide range of diseases including syphilis. As usual, in the case of diseases such as syphilis, these hawkers diagnose and prescribe drugs without laboratory check-ups. It is worth noting that several women participants expressed satisfaction with the hawkers because they sell drugs at reduced prices, and they are willing to dispense their drugs for any amount of money (regardless of the appropriate dose).

4.4.5. Reproductive health services.

4.4.5.1. Antenatal and Maternity Health services.

Full-fledged antenatal and maternity centres with laboratory facilities are not within easy reach by the women in rural areas. In Kasana study site, the nearest government operated health centre with some of the above facilities is Nakifuma. In Kasokwe, the nearest is Bbale. In both cases, the centres are approximately seven kilometres away. Both centres do not have laboratory-testing services, in spite of the importance of STD's among rural women. This means that pregnant women do not have their blood and urine samples checked in order to (among others) rule out STD's that could otherwise be passed on from mother to foetus.

4.4.5.2. Family Planning services.

There is limited use of Family Planning (FP) services in the rural areas. In addition, the quality of the services in the rural areas is generally poor. Many of the women participants, including those that were using the services, disclosed that they needed to be educated about FP. In addition, the counselling received from the service providers was found inadequate. In response to question number eight (see appendix C), several women participants who were using the services disclosed that they were asked some but not all of the enlisted sub-questions before making method choices.

Lack of Family Planning education and inadequate counselling were found to be a major reason explaining the widespread misconceptions about the side effects of FP among the women. This in turn explains the limited use of the services in these areas. For instance, many of the women that had not yet used the FP services, but perceived a need, disclosed that they would not use the services because they were afraid of the negative side effects as expressed in statements below.

> *We want to use Family Planning services but the side effects are pushing us off...,we fear pills because those who have tried them have experienced side effects. We hear that other effects include abnormal babies (participant # 33).*
>
> *I fear using Family Planning services because my sister-in-law had continuous bleeding for three months (participant # 50).*
>
> *I have not used Family Planning services because I'm afraid. People say that women who use the services [such as pills and injectables] can get chronic backache, irregular bleeding.... (participant # 54).*

Those women who had used the services explained that they had to abandon them because of their side effects. Many of those who are still using the services explained that they are experiencing complications and expressed intentions to abandon the services.

> *When I joined the Family Planning program, I experienced some problems. I used to receive injections but this used to cause swelling and pain in my legs and arms. I told the doctor and was given pills but this did not help. I had to quit, and now I'm better (participant # 28).*
>
> *I have not fared well with the pills, I had frequent headaches.... then I went*

> *for injectable depo provera but this made me bleed off and on, and I'm now considering withdrawing from the program (participant # 32).*

Besides, as stated earlier in this chapter, married women lack the ability to make independent decisions that affect their health, including the use of Family Planning services. This was found to be another major reason explaining the limited use of Family Planning services. The women have to ask for permission from their male spouses, most of whom are strongly opposed to the idea of FP. As some of the women put it, they feared the wrath of their spouses and would not dare to go against their spouses' wishes. Other than the major reasons, money, distance, and time were found to be factors that explained the limited use of Family Planning services.

4.5. Rural women's recommendations for change.

Based on their experiences with the health care services, the women participants made a number of recommendations for the improvement of the services. The women recommended health education programs by the Ministry of Health, emphasising that the programs be targeted mainly at the rural communities. They added that the major focus be on issues of special concern to women, such as Family Planning, breast and cervical cancers, and other aspects of reproductive health. In the case of Family Planning, the women emphasised that this health education be mainly targeted at rural men since the men are a major barrier in Family Planning use among rural women. The following view by a focus group participant was echoed by several individual participants.

> *Family Planning education should be mainly for men because they are the ones who stop their wives from using the services.*

In addition, some women suggested confidential Family Planning services in order to serve women who are restricted by their husbands.

Women participants also suggested that the government establish well-facilitated health care centres near the rural areas. These centres should have well-trained resident health care providers who are always available 24 hours a day. The women emphasised the need for laboratory and x-ray equipment at rural clinics. The availability of the required drugs in rural clinics was also recommended. The women added that these drugs and the related services be provided to the rural women free of charge whenever they are needed. It is worth noting that at present, the Ministry of Health provides drugs to the population at subsidised prices.

The participants recommended the extension of women's clinics such as antenatal and maternity centres to the rural areas. The deployment of more midwives in the rural areas was also recommended. In the case of Traditional Birth Attendants (TBA's), the women suggested more training and facilitation. This should enable the TBA's to carry out minor surgical procedures, such as stitching. This, the women reasoned, was necessary because many deliveries take place at home/out of health care institutions. As one concerned participant put it:

> *I got torn during delivery at home but was never stitched and this really bothers me (participant # 52).*

In view of the fact that some women participants are not aware of the presence of Community Health Workers (CHW's) in their areas, more deployment, training, and community outreach of CHW's was recommended. This, according to the women, would increase the CHWs' involvement and skills in community health programs.

About their gender preferences, most of the participants disclosed that they prefer female health care providers. The major reason given by the women is that the female providers understand the women's problems much better than their male counterparts. The women who were less concerned about gender preference expressed a female preference in case of reproductive health problems.

4.6. Health care providers' perspectives on rural women's experiences.

It is important to mention that the Ministry of Health has been making some effort to generally improve services in those health care centres that are easily accessible to the rural residents. One remarkable effort is the development of the *Procedure Manual for Family Planning and Maternal Health Service Delivery* (MOH & INTRAH, 1995). This was in specific response to the rural women's inaccessibility to well-facilitated health care centres, as evidenced by the findings above. The manual provides guidelines for managing various aspects of reproductive health, including Family Planning, STD's and breast and cervical cancers. In the prevailing situation of general inaccessibility to laboratory services by the rural women, the manual is potentially a useful resource for health providers if it is used effectively. In Mukono District, the manual has been distributed to virtually all health care units including village aidposts such as Kasokwe, which is located in one of my study sites.

As stated in the methodology chapter, the interviews with the health care providers were intended to triangulate the data that were collected from the rural women participants. Guiding questions (see appendix C) were used but these were adjusted to focus on issues of concern to the rural women participants.

In addition to the health problems outlined by the women participants, the health care providers mentioned candidiasis, genital herpes, worms, as some of the other health problems experienced by rural residents in general. The participants consistently disclosed that there is a high incidence of STD's among the rural women. This was consistent with the women participants' views. The participants added that for the population in Kasana and Kasokwe study sites, the nearest government health care facility with laboratory-testing services is Kayunga Hospital. For both study sites, the hospital is over 10 miles away. The participants agreed with women participants that better diagnosis and treatment should be promoted by the Health Ministry in order to reverse the high incidence of STD's among the women.

In most of the health care facilities, the participants disclosed that they provide awareness education about breast cancer. This is in contradiction to the reports of rural women participants who consistently reported that they only hear of breast cancer, but have not been educated about it. However, the participants agreed with the women by disclosing that they never advise them to conduct Breast Self-Examination (BSE). In some of the health care facilities, the providers disclosed that they never provide awareness education about both breast and cervical cancers.

In the *Procedure Manual* referred to above, it is indicated that in the entire country, the Ministry of Health operates only one central laboratory that tests for cervical cancer (p. 203). This laboratory is situated in Kampala (Uganda's capital). Although the manual provides procedures for obtaining and sending Pap smear samples to the central laboratory, participants disclosed that these procedures have not yet been implemented in the health care facilities. They added that no awareness education is being carried out about cervical cancer. This is in agreement with rural women's accounts about cancer education in their communities.

Some health care providers disclosed that some private practitioners are not strictly adhering to ethical standards of medical practice. They explained that most private practitioners are more profit-motivated than service-oriented. One participant disclosed that in the current competitive environment, several private practitioners often suggest to rural women that they offer better services than the government. They do this by promising that they are always willing to provide services on credit. These private practitioners also give the wrong impression that they charge lower fees for their services than the government. The participant argued that the lower fees are a result of under-prescribing the appropriate dose. Some women participants similarly reported that they tended to avoid government facilities because private providers are kind and willing to extend credit. As one woman participant stated:

> *I rarely visit the government aidpost because I prefer those who can tolerate us for credit (participant # 49).*

Health care providers generally agreed with women participants that there is a problem of understaffing, especially in rural health care facilities. Some providers disclosed that some of the health units are staffed by a single health worker. The same views were raised by the women participants.

The problem of failure to refer patients when it is necessary was also identified by providers. Traditional Birth Attendants (TBA's) were particularly mentioned for their habitual failure to promptly refer rural women with delivery complications for better care. The participants argued that TBA's refer women to formal services when it is almost too late, and therefore they contribute to maternal and child mortality.

Health care providers generally agreed that specialised services for women are not well facilitated even at the district's top health care centres. For instance, maternity clinics lacked adequate delivery instruments. As one health care provider stated:

> *We do not have enough delivery instruments in the hospital. Currently there is only one set, yet about four sets are required.*

The health care providers contradicted women participants on the issue of Family Planning (FP) education and counselling. All providers that were interviewed disclosed that they always offer FP education and counselling to those rural women who seek health care from government facilities. This is in spite of the view by many of the women participants that they were in need of FP education and more counselling. However, the health care providers agreed that there are misconceptions among rural women, such as the beliefs that FP causes uncontrolled bleeding and chronic backache, and that these beliefs are especially generated by unethical private FP providers. These private providers, the participants reasoned, are more motivated by money, and often do not have the time or the necessary knowledge for counselling women clients. Some of the providers disclosed that some private practitioners were providing FP services without the relevant qualifications.

Health care providers generally concurred with women participants on various recommendations for change. These include FP education targeting men, establishment of well-facilitated clinics near rural communities, improving services in the hospitals, further training of TBA's, deployment of more staff to serve rural residents, and the establishment of STD clinics near rural areas.

In addition to the women's recommendations, the providers suggested sensitisation of health practitioners on the need to refer appropriate cases. They also suggested strict regulation of private health practitioners to improve ethical standards and services.

CHAPTER V: DISCUSSION

5.1. Introduction.

The purpose of this study is to assess the quality of health care for Ugandan rural women. As explained in the methodology chapter, qualitative research methods were used to collect the data from both rural women and health care providers. In this chapter I begin with a summary of the findings. This is followed by a detailed discussion of the findings in which I revisit the common health problems and needs as reported by the rural women. In light of these problems and needs, I examine the available health care services in order to ascertain the nature of the gap between the problems and needs and the services. Throughout the discussion, I compare the findings with the work of other researchers in related fields of study. In this chapter, I briefly present the emerging theory. It is on the basis of this theory that I discuss the implications of the findings for the community-based health care approach, and how the approach can be tailored to suit Uganda's rural conditions. Three important aspects of rural women's health are also identified. It is in this chapter that I assess the quality of health care for Ugandan rural women.

5.2. Summary of the findings.

One of the major findings of this study is that the three most common health problems as perceived by the rural women are all related to women's reproductive health. STD's were particularly mentioned. In addition, recurrence of the STD's appears to be a significant problem among the women. In-spite of this situation, health care units in the rural areas lack laboratory-testing services that would enable diagnosis that is more reliable. Health care providers rely on written guidelines as spelled out in the *Procedure Manual* already mentioned in the previous chapter. Many rural women participants reported abdominal pain, which also tends to be associated with reproductive health problems.

Stress appears to be another health problem afflicting many of the rural women, although the problem seems not to be recognised by the health care providers. In the case of cancers of the breast and cervix, there is general lack of awareness about the diseases among rural women. This supports the women participants' revelation that the Ministry of Health has not made an effort to educate and sensitise women about breast and cervical cancers. This revelation is in part disputed by health care providers, most of whom disclosed that they educate women about breast cancer whenever they see women patients. The providers generally agree with the women that there is no awareness education about cervical cancer. The Health Ministry operates only one testing centre for cervical cancer in the entire country. This centre is located in the capital, Kampala, which is over 100 kilometres from the Kasokwe study site, and over 30 kilometres from Kasana study site. Violence against women is common but is not considered an important factor by the women.

The women are generally not satisfied with the health care services, citing understaffing in rural health care centres and absence of some of the most required services such and laboratory-testing facilities. There is also not enough provider-to-client feedback and patient referral is not always done when necessary. In addition, there is a problem of unsupervised drug hawking.

There is not enough sensitisation about Family Planning (FP) as evidenced by the fact that many women participants expressed need for FP education. Consequently, the women have a variety of misconceptions about the effects of FP. Some of the misconceptions about FP effects include the perceived risk of having abnormal babies, and experiencing chronic backache. This has resulted in limited use of the services in the rural areas. Another major factor explaining the limited use of FP services among rural women is the discouragement men express to their wives when women try to obtain FP services. Other limiting factors include time, physical inaccessibility to clinics, and lack of money.

Ethical standards of medical practice are not strictly observed. For instance, to several private practitioners, it seems like the desire to save life and improve the health of clients comes after their interest to stay in business. In this study, this practice was evidenced by the fact that several private health care practitioners do not devote adequate time for patient advice, and that the private practitioners are willing to dispense medication with any amount of money regardless of the appropriate dose. This often compromises quality care.

5.3. Discussion of the findings.

5.3.1. Common health problems/needs vis-à-vis the available services.

5.3.1.1. STD's and abdominal pain vis-à-vis the relevant services.

Thus far, the Ministry of Health has done a commendable job of promoting awareness among both the urban and the rural populations about the spread and prevention of STD's and HIV/AIDS. Nevertheless, there is need for a more comprehensive program to address STD's. The fact that the first three health problems (see Table 1) are all related to women's reproductive health, notably STD's, suggests serious need for the relevant specialised services to be more accessible to the women. Rural women's consistent reports f STD's is consistent with Okojie's (1994) finding that women in Africa reported frequent histories of STD's. Similarly, Shimkin (1996) reports that gonorrhoea, non-specific pelvic inflammation, and syphilis are highly prevalent in East and Central Africa. As the findings reveal, the problem of inaccessibility to these services including laboratory testing, is yet to be effectively addressed.

Many of the women participants reported recurrence of the STD's, particularly syphilis. The recurrence of the diseases among the women may be attributed to drug resistance, wrong diagnosis of women's health problems by both the women and some health care providers, or a re-exposure to the disease. Disease recurrence is a potentially broad topic, especially in regard to STD's whose diagnosis in rural Uganda is largely based on written guidelines. In such conditions, there seems to be no reliable (laboratory) documentation on the type and incidence of STD's among the rural population. A research approach that would involve clinical laboratory tests of participants might be one way of filling this research gap, as it would also provide insight into the extent of disease recurrence attributable to incurable STD's such as genital herpes and genital warts. The issue of disease recurrence can only be addressed exhaustively as a separate research topic, using both qualitative and quantitative research methods. Thus, in the following few paragraphs I endeavour only to discuss the different scenarios under which the recurrence may arise, given the prevailing rural conditions.

Drug resistance might be a result of self-medication. Several women are using the self-medication strategy because they reportedly cannot afford to seek treatment from health care facilities. The causal relationship between self-medication and drug resistance is especially likely in the rural areas where people are not generally educated about the possible negative outcomes of self-medication. One reason for the possible causal relationship is that even when the women have made the right diagnosis, they may buy incomplete drug doses. An incomplete dose that cannot effectively destroy the disease organism allows it to mutate and develop into a drug-resistant strain. This is consistent with the view that the resistant cells are the adaptive product of interaction between the drug and the bacterial cell (Falkow, 1975).

Similarly, women frequently do not know how to administer the drugs, which often reduces the efficacy of the drugs they are using. For instance, the women often have no idea about the proper time interval to be observed as they administer the drugs. Thus, they sometimes go beyond the required time interval. The delay means that the optimum dose required to effectively rid the body of the disease organisms is not maintained in the body. This could also explain the possible relationship between self-medication and drug resistance. The practice by some private practitioners of prescribing and dispensing drugs at an inappropriate dosage, according to what the client can afford, is likely also conducive to clients developing drug resistance. This practice was identified not only with drug hawkers, but also with more organised private practitioners.

Other than drug resistance, recurrence of STD's might be a result of wrong diagnosis and thus, the wrong drug prescription. Self-medication is also likely to be the cause of wrong diagnosis. Given that the women are not professionally competent to diagnose many of their health problems, it is highly probable that they could make wrong diagnoses. Thus, they buy drugs for diseases other than what they are suffering from, and effectively do not treat their real health problems. Health care providers might also contribute to the recurrence of STD's through wrong diagnosis. Some private practitioners, particularly drug hawkers, seem to be most interested in marketing their drugs. Thus, it is likely that in many cases they prescribe only those drugs that they have in stock, regardless of whether the drugs are the most relevant for the disease.

The general practice of diagnosis based on written guidelines and no laboratory results means that there is lack of diagnostic precision. In such a situation, it is possible for health care providers to make wrong diagnoses and prescriptions. The possibility for wrong diagnosis and prescription by health care providers is supported by the 1994 study on the quality of care in 12 health units in Kabarole district (Kilian et al., 1997). The study found that the "ability to interpret findings and make appropriate decisions" was one of the categories in which health workers performed less well (p. 12). Golladay (1984) states that in developing countries, many health workers prescribe three or more drugs to patients when in doubt about the cause of illness, and that this practice promotes drug resistance (p. 244). However, even in cases of correct diagnosis and prescription, the absence of testing services means that the women cannot post-test to be sure of complete recovery.

The quality of advice provided by some health care practitioners to rural women might suggest lack of competence in their fields of practice. A case in point is the STD services whereby some health care providers have reportedly told the rural women that syphilis is incurable. This kind of advice has the potential to increase the recurrence of the STD, as the women are likely to be discouraged from seeking health care, since they believe their STD is incurable.

As the findings of this study reveal, abdominal/pelvic pain is one of the three most common health problems among rural women. A number of factors have been identified as possible causes of this pain. STD's have been identified among the causes of non-specific pelvic inflammation that causes abdominal pain. Rocker (1990) identifies chlamydia trachomatis, herpes virus, and pallipoma wart virus, as some of the infective agents in pelvic inflammatory disease (p. 111). Other possible causes of abdominal pain include fibroids (common tumours found in the female genital tract), recurrent ovarian cysts, and uterine malposition (Rocker, 1990; Levy, 1998). According to Rocker (1990), uterine malposition may result from a laxity of the uterus support ligaments (p. 105). The author adds that malposition may result into the uterus pressing on the rectum, or causing the cervix to impinge on the urethra, which in turn will initiate urinary hesitancy or, in the extreme, retention of urine (p. 105). Pregnancy can also trigger the pain. In this case, the common causes include abortion, and the expansion of the uterus into the abdomen due to the growing foetus. Chamberlain

(1992) states that during pregnancy, the uterus expands into the abdomen, and that this sometimes leads to retention of urine in the bladder as a result of the bladder being pushed to the abdomen, making it difficult for the urine to pass (p. 47). Abdominal pain might also be orthopaedic, resulting from skeletal dysfunction (Jones, 1990). According to the author, orthopaedic causes of abdominal pain in females are usually made worse by exercise and weight bearing and relieved by rest (p. 150). Given the strenuous nature of work that many Ugandan rural women do, it is likely that orthopaedic causes are some of the significant causes of abdominal pain among the women.

Effective management and treatment of abdominal pain is critical in order to avoid complications such as cancer, as in the case of ovarian cysts (Levy, 1998), and depression (Steege, 1998). Steege (1998) notes that in the presence of chronic pain, patients often experience depression, which co-evolves and worsens together with the pain (p. 3). In the case of orthopaedic pain, Jones (1990) argues that arthritis of the hip, for instance, must be treated vigorously if serious degenerative effects are to be avoided (p. 155).

5.3.1.2. Orthopaedic, Gynaecological, Antenatal and Maternity needs and services.

Rural women's perceptions on their health problems suggest a high incidence of reproductive health problems. This calls for accessible STD, orthopaedic, gynaecological, antenatal, and maternity services. The fact that abdominal pain is a function of multiple factors suggests that effective management and treatment of the pain requires a joint effort of all the above services. Orthopaedic care would deal with skeletal pains such as those of the spine and joints. Gynaecological care is important for the diagnosis and treatment of fibroids, ovarian cysts, and uterine malposition. Antenatal care is particularly vital for pregnant women with STD's such as syphilis and genital herpes as these diseases can easily be passed from mother to foetus. According to Rooney (1992), information on prevalence of syphilis, gonorrhoea, and other STD's in the population is needed, and that this is an area in which antenatal care can clearly have an important benefit for mother and child. The author quotes a study in Zambia which found a syphilis prevalence rate of 8% amongst women that were attending antenatal clinic, and a predictive value of 58% that these pregnancies would result in abortion, stillbirth, prematurity, low birth weight, or congenital syphilis, compared to only a 10% chance of the above antenatal problems amongst the women that did not have syphilis (p. 31). The study found that antenatal services such as screening and treatment have been found to be effective against adverse effects of pregnancy. For instance, during this intervention study that involved the screening and treatment of participants, although the screening and treatment were sub-optimal, the percentage of adverse foetal outcomes was halved (p. 31).

In addition, because of their financial difficulties, many rural women cannot afford a balanced diet. This exposes the women to the risk of anaemia, a result of a reduction in haemoglobin concentration in the blood (Rooney, 1992). According to the above author, the risk of anaemia is more real for pregnant women whose haemoglobin concentration falls slightly in mid-pregnancy as a result of the physiological changes that the women undergo during pregnancy (p. 18). This situation puts the life of both the mother and the foetus at risk. The author points out that the role of antenatal care in preventing or ameliorating the effects of anaemia includes: (1) detection of those women at increased risk of serious bleeding in labour and ensuring that they deliver in a facility which is adequately equipped, (2) detection of adverse symptoms and signs developing during pregnancy and referral for prompt investigation and treatment, and (3) reduction in the prevalence of anaemia, so that women have a greater haematological reserve to withstand blood loss. The rural women's inaccessibility to the above services might be one of the major factors explaining the high maternal mortality in Uganda, as revealed by Kilian et al. (1997, p. 19).

In the case of maternity, the majority of rural women deliver at their homes. This finding is consistent with the revelation in the Human Development Report (1997), that of all the births during the period 1990-1996 in Uganda, only 38% were attended by trained health personnel. Similar findings were reported for the districts of Kabarole and Bundibugyo in 1995. It was found that deliveries at hospitals or health facilities were only 16.3% for Kabarole, and 15.0% for Bundibugyo (Kilian et al., 1997, p. 18). The services provided by Traditional Birth Attendants (TBA's) are currently not adequate in terms of coverage and quality of service. Several women participants and health care providers expressed the need for more TBA's and more training to improve the work skills of the TBA's, as well as their knowledge about working with formal health care providers.

Currently, STD, gynaecological, antenatal and maternity services are generally inaccessible in Ugandan rural areas. Therefore, the rural women are not effectively monitored and treated for the STD's and other pelvic inflammatory diseases, anaemia, and other problems that increase risk during pregnancy and childbirth. Many of the rural women cannot afford health care under such conditions. A 1995 household interview survey on knowledge, attitudes, practices, and beliefs (KAPB) in two other districts of Kabarole and Bundibugyo (Kilian et al., 1997, p. 18) yielded similar findings. According to the survey, the median number of antenatal care visits per pregnancy was three in both districts. It is important to note that the above figures could be much lower for rural areas, after controlling for rural-urban differentials. The need for the above services was consistently expressed by the women participants.

5.3.1.3. Family Planning (FP) needs and services.

Because of birth spacing and excessive childbirth problems, many women are expressing need for FP. This is supported by the Kabarole and Bundibugyo survey (Kilian et al., 1997) which found that 48.1% and 43.2% of the women in the two districts respectively, intended to use, but were not yet able to use the FP services (p. 18). These figures could be much lower for rural areas after controlling for the rural-urban differentials. In spite of this seemingly acute need for FP among rural women, a look at the existing services suggests low coverage in terms of education and counselling, and contraceptive distribution in the rural areas. The demand and supply gap of the services is wide.

According to some of the interviewed health care providers, the rural areas have Community Based Contraceptive Distributors (CBCD's) whose basic function is to distribute contraceptives to the women. The idea is to extend outreach services to the women who usually have problems accessing health centres that provide FP services. These CBCD's are supposed to be regularly supervised by the health centres. However, the fact that many women are expressing an unmet need for both FP education and services suggests that the CBCD's are not reaching many rural women. Some of the health care providers revealed that a significant number of rural women are not aware of the FP services in their areas. Besides, some of the health care practitioners who provide the services in the rural areas lack adequate training, especially among the operators of rural drug shops. The need for FP education and counselling is evidenced by the widespread misconceptions about the effects of FP, and the attendant widespread FP program failure in the rural areas. The FP failure is reported by the 1995 Uganda Demographic and Health Survey (UDHS) report, which found that only 5.1% of rural women use modern methods of contraception (Kilian et al., 1997). Similarly, the present study reveals limited FP use among rural women because of misconceptions, such as the belief that the women will deliver abnormal babies, and that they will suffer from chronic backache. Women that have not joined the FP program are afraid of joining, while many of those who have already joined are withdrawing from the FP program. This further suggests that the Ministry of Health has not provided enough FP education and counselling. The finding is also consistent with that of the World Fertility Survey that was conducted by the World Health

Organisation (WHO) in the mid-80s (Dixon-Mueller, 1994). The WHO study revealed that in developing countries, FP programs offer little or no personal counselling, method choice, or follow-up care.

Like in many other countries, health policy makers in Uganda have not yet practically recognised that FP programs cannot succeed especially in rural areas without taking into account the socio-cultural context of the rural society. Shimkin (1996) similarly argues that FP programs usually are poorly related to broader issues of women's health and status. In Uganda, the problem is reflected in the current FP programs that ignore the important role of men/spouses in determining FP use by the women/spouses. This problem was also identified by the women participants who suggested FP education programs for not only themselves, but men too.

5.3.1.4. Cancers of the breast and cervix - needs and services.

Whereas the rural women have generally heard of both breast and cervical cancers, they lack basic knowledge about the two cancers. Thus, they are not aware of the risk factors nor are they able to identify early symptoms. This situation suggests that the women are in serious need of education on breast and cervical cancers. In spite of the above situation, the Ministry of Health has not yet engaged in a major effort to educate women about breast and cervical cancer. Currently, there is reportedly an effort by health care providers to sensitise women about these cancers. However, the women's persistent lack of awareness about the cancers raises serious questions about the adequacy and consistency of that effort. Note that none of the women participants in this study knew how to conduct a simple Breast Self-Examination (BSE).

There is also a serious need for facilities such as testing centres, more particularly for cervical cancer. This is because the persistent reports of STD's by the rural women suggest that the risk of cervical cancer is high among rural women. For instance, researchers have found a strong link between cervical cancer and the infection of the cervix by the human papilloma virus, which causes genital warts (WHO, 1994). In spite of the above situation, the Ministry of Health operates only one testing centre for cervical cancer in the entire country. This centre is located in the capital, Kampala, which is generally inaccessible to Uganda's rural women. The *Procedure Manual* outlines the steps to be taken by the health care providers, from obtaining a Pap smear to sending the specimen to the laboratory in Kampala. However, this exercise is virtually not implemented by health care providers in the rural areas, most likely because cervical cancer testing does not seem to be a priority issue in health care.

The critical need for the Ministry of Health to improve awareness about the two cancers and accessibility to testing services is supported by Okojie's (1994) finding that the cancers are leading causes of death in developing countries. The writer adds that cervical cancer is at the top of other cancers that affect women in sub-Saharan Africa.

5.3.1.5. Other important issues related to women's health.

I consider professional standards of medical practice such as qualifications of health care providers and adherence to professional ethics, to have a strong positive association with the quality of health care services. In view of the above, there appears to be inadequate supervision, especially of the private health care providers by the Ministry of Health. In addition to the services for which private health care practitioners qualify and are licensed to provide, some of these practitioners seem to be providing services for which they do not qualify. Consequently, the quality of care is compromised. This is also true when some of the private health care practitioners are seemingly preoccupied with their business interests and caring less about the quality of services that they are providing to their clients.

Some of the health care providers do not give full feedback to their rural women clients. These providers only ask the women to buy the prescribed drugs without telling the women what health problems the drugs are intended to treat. Consequently, the women are denied the opportunity to be aware of their own treatment and its likely consequences. The effect of inadequate provider-client feedback is more adverse in the case of serious health problems, such as breast and cervical cancer. In such cases, women are not able to monitor themselves for possible relapses. Therefore, women need education on what precautions should be taken to avoid the same health problems in future.

The rural women's lack of concern about the violence meted out against them by their spouses is largely attributable to their socio-cultural relationships and expectations. As pointed out in the previous chapter (see 4.2.1), the women are expected to be submissive to men/spouses, and thus, the women consider the violence as a normal practice through which their spouses exert control over them. Although there has been significant research effort on violence against women (VAW), there appears to have been little or no research effort on the perceptions of women, especially in rural areas of the developing world, about VAW. I consider this a crucial area of study because of my belief that the success of the fight against VAW depends significantly on the active participation of the women. Thus, information on women's perceptions about VAW might be useful in the identification of related needs, such as rising women's consciousness on the negative health implications of VAW, and the need for the women's input in the fight against the practice.

5.4. The Emerging Theory.

The theory emerging from the above data is that Ugandan rural women live and work under an unfavourable socio-cultural, economic and environmental context. This context has served to make the women vulnerable to ill health. Moreover, when the women are in need of health care, conditions such as inaccessibility to health care facilities, and lack of time and money, as well as dependence on men, limit their ability to seek health care. In turn, the women have over time developed coping strategies to deal with above situation. These strategies have not been sufficiently helpful to rural women, as the women continue to report a wide range of health problems. In spite of the above difficulties, health policy makers have demonstrably not yet fully recognised the significant role of the above context in determining rural women's health. This is reflected in both the quality and quantity of the existing services. Until now, Uganda's health care services remain largely inaccessible to the rural population, particularly women. Services that are needed most by the women, such as FP, antenatal, maternity, and gynaecological services, as well as laboratory services, are concentrated in urban areas. In brief, there is lack of equity in health care as the services are not gender sensitive, and thus the quality of health care for Ugandan rural women remains poor. My study calls for greater attention to the relative importance of time available to women, the women's economic status, their independence of men, distance to, and type of health services, and the overall health, of rural women.

5.5. Implications of the findings for the community-based health care approach, and how the approach can be tailored to suit Uganda's conditions.

By seeking to provide services where they are needed, and encouraging active user (women) participation in health care and promotion, the community-based health care approach provides a theoretical framework within which equity in health care can be realised. Equity in health care may mean that services are provided according to need. Thus, the magnitude and urgency of the individuals' or population groups' health problems would determine the type, magnitude, and urgency of health care intervention.

Given Uganda's resource base, the community-based health care approach may not be entirely applicable. However, the approach provides a basis upon which the provision of health care in rural areas can be greatly improved. In view of the findings, the approach is reviewed below, and suggestions are made on how it can be tailored to suit Uganda's conditions. In the review, I identify important attributes of community-based health care and examine the extent of their application in the rural areas of Uganda. Suggestions are made on the basis of rural women's health care priorities, and the available resources.

One of the important attributes of community-based health care is that it seeks to integrate the biomedical, behavioural, and socio-environmental models of health care/promotion. The need for the integrated approach is more so in the case of developing countries such as Uganda because of the significant role that the socio-environmental factors play in determining population health. An elaborate presentation of the role of the socio-environmental factors is provided in the findings chapter under *context, conditions* and *strategies*. In this study, poverty and cultural limitations (see 4.2.1) are identified as some of the major factors undermining the health of Ugandan rural women. While the Health Ministry realises the appropriateness of the above approach, in rural Uganda, the Ministry has demonstrably shown less effort on the behavioural and socio-environmental aspects of community-based health care delivery.

On the one hand, given the health situation in rural Uganda, a practical approach would recognise biomedical care as vital in combating the widely spread infectious diseases. On the other hand, equal emphasis would be placed on the behavioural and socio-environmental aspects of health promotion, as these would enable the population to take primary responsibility for their own health through behavioural and socio-cultural change. A discussion of the other attributes of community-based health care sheds more light on the practicability of this approach.

Another attribute of community-based health care is that the services are close to the people who need them. This means that a study of the community's health problems and needs would be made so as to provide accessible relevant services. Services such as ambulatory and acute care would be available for those in emergencies. Specialised services for women and children would also be accessible. Currently however, most of the services that are required in the rural communities, such as ambulatory and acute care and several specialised services, are usually not available within the communities, and can only be accessed with difficulty in urban areas.

Given the national budgetary constraints, ambulatory and acute care may not be feasible in rural Uganda. However, even with the available resources, a workable approach can be designed so that health services are brought closer to the people. This would minimise emergencies that would otherwise call for ambulatory and acute care services.

A beginning point would necessarily be a gendered approach to a health needs assessment of the rural community. Priority would then be given based on the gravity and urgency of the health problems. Since this study identifies the importance of STD's and abdominal pain from the perspectives of rural women, priority would then be given to these problems, as well as the related need for cervical and breast cancer testing. According to this study, other needs that require urgent attention are gynaecological, antenatal and maternity needs. One of the cost-effective ways to provide STD, gynaecological, antenatal and maternal services, might be through weekly, bi-weekly, or tri-weekly community visits by the relevant medical specialists.

The locations of these outreach services might be determined based on the need to provide as much coverage as possible per visit. This would save the Ministry of Health the costs of establishing and maintaining full time services in the rural communities, without compromising accessibility to these highly needed services. Besides, the community outreach approach is appropriate for Uganda in light of the current problem of inadequate health care professionals. This is because the outreach programs do not necessarily require the health professionals to be permanently deployed in the rural communities. Rather, the few professionals that are usually based in hospitals would be able to reach out to a bigger rural population. As the literature reveals (see chapter 3), a similar approach of providing outreach antenatal and child clinics on weekly basis proved successful in Uganda in the 1970's.

The other attribute is the idea of the health human resources continuum. In the case of Uganda, this continuum would include formal caregivers (both government and organised private health care providers), and informal caregivers (drug hawkers, traditional healers, and women). The idea of the continuum appears to have not received serious consideration by health policy makers in developing countries like Uganda. With this idea, the efforts of all those who contribute to the objectives of the health care system are recognised. This means that in addition to the formal caregivers, informal caregivers who in the case of rural Uganda are predominantly women are recognised as an integral part of the health care system. Rural communities in Uganda are not adequately covered by formal health care. Thus, it is the rural women who practically fill the gap created by the inadequate formal care, as they usually cater to the health care needs of themselves and their families.

A related attribute is the need for greater responsibility by individuals for their wellbeing. Community-based health care presumes the need for consumer participation in health care/promotion. Although the women possess broad knowledge about traditional therapies, they still significantly lack the necessary education and training to optimally utilise their caregiving potential. The inadequate health education and training of rural women has hampered women's ability to take greater responsibility in health care/promotion. In spite of the women's significant success in their caregiving work, they are sometimes not sure about their diagnoses and prescriptions (especially) of modern medicine, as well as appropriate disease-prevention practices. The need for health education and training demonstrates an imbalance in the development of the health human resources.

In spite of the national resource limitations, the need for the development of health human resources, especially in the informal sector, is a priority issue. With the use of the already existing Local Council (LC) infrastructure through which grassroots women are regularly mobilised for community efforts, the Ministry of Health can design women's education and training programs on a regular basis. During these programs, the women would be educated about disease prevention, and trained to diagnose and treat common minor ailments. It may be argued that the problem of inadequate resources further justifies this approach. This is because the approach would enable the population to effectively take more responsibility for their own health promotion and care, leading to improved health, which might in turn lead to a reduction in national health care spending.

5.6. Family Planning, Abdominal pain, and Stress.

This study identifies three important aspects of women's health that call for more emphasis, both by health policy makers and researchers. Relevant policy recommendations and suggestions for future research are presented in sections 7.2 and 7.3 respectively.

5.6.1. Family Planning.

As the literature suggests (see chapter 3), most of the previous studies have addressed various aspects of FP such as education, counselling, and methods of contraception. However, these studies have not addressed men's role in FP use. Through the discussion of the socio-cultural and economic context (see 5.2.1), this study highlights the contextual realities of society in developing countries, particularly Uganda, and their effect on women's health care seeking behaviour. The study identifies the major role that the men play in determining FP use, particularly the power to decide whether the women/spouses should use the FP services. Therefore, it is argued that the success of FP programs especially in rural Uganda largely depends on the men's consent and support.

5.6.2. Abdominal pain.

Abdominal pain was found to be one of the most important health problems as perceived by the Ugandan rural women. Previous studies have focused more attention on STD's in general as a major factor determining women's reproductive health, and less attention on some of the related factors, notably abdominal pain. Literature reveals that so far, many studies on women's health have considered the pain to be of secondary importance, usually being briefly mentioned when discussing STD's. In this study, an in-depth examination of abdominal pain puts to the fore the fact that the pain is a function of STD's, as well as pregnancy, gynaecological, and orthopaedic factors. In addition, this study points out that abdominal pain is one of the major factors likely related to women's morbidity in rural Uganda, and is equally important to women as STD's.

5.6.3. Stress.

Stress appears not to be considered as a major health problem in rural areas of the developing world. This is reflected both in the health care programs and in much of the available research work on women's health in the rural areas. Similarly, the data collected for this study reveal that relevant services, such as counselling are not available for the rural women. As the literature reveals, much of the previous research work has only briefly mentioned stress when discussing other important aspects of women's health. The research has mainly focused on the health problems that affect women's physical health. Thus, stress, a mental health problem, has hitherto not been considered as possibly a major contributor to rural women's morbidity. Though not conclusive, this study identifies the possibility that stress is one of the major health problems among Ugandan rural women. This finding is based on the economic and socio-cultural context in which the women live (see 4.2.1), and the women's own revelations on how they feel about their daily life experiences (see 4.3.1.3).

CHAPTER VI: CONCLUSIONS

6.1. Review of research questions and objectives.

The research questions as stated in chapter one (see 1.3) are revisited, followed by a summarised presentation of the answers to each of my research questions. These answers are then compared with the study's overall objectives in order to establish whether the objectives were fulfilled. The first research question was: What are the common health problems/needs of Ugandan rural women? This question is addressed under section 4.3 of chapter four. In summary, the most common health problems as reported by the rural women are related to the women's reproductive health, particularly STD's, abdominal pain, and genital itching/sores. Malaria, headache, and respiratory health problems are perceived by the women as some of the other important health problems. As elaborated on in chapter five, the rural women's perceived importance of reproductive health problems such as STD's (see 5.3.2.4) is a cause for concern about the risk of cervical cancer. Likewise, abdominal pain might signal the risk of uterine cancer (see 5.3.2.1). Stress appears to be another major health problem among rural women.

Section 4.4 of chapter four addresses research questions two, three, and four, that is: What is the nature and type of health care services that are available for the rural women?, How accessible to the rural women are the existing health care services?, and What is the nature of the gap between the existing health care services and the health needs of the rural women? In summary, the nature of the services is such that the services are generally not satisfactory to the rural women. Provider-to-client feedback on the diagnosed health problems is not always given, and thus, the rural women frequently do not know or understand the diseases they suffer from. Patient referral is rarely made in rural health care facilities, even when it appears to be the most appropriate option for the patient. This contributes to the risk of mortality. Drug hawking is a welcome form of response to the situation of health service inadequacy in rural areas. However, the hawkers' methods might be causing more harm than good to recipient women in rural Uganda, because the hawkers dispense drugs for major diseases that require specialised care and laboratory examination, such as STD's. As discussed earlier, this practice has the potential to exacerbate disease recurrence. There is a limited range of services that are accessible to the women. The services that are most needed by the women, such as laboratory testing, STD, gynaecological, antenatal, and maternity services, are difficult to access because they are concentrated in big hospitals and clinics in urban areas. By identifying the various gender-specific needs of Ugandan rural women vis-à-vis the health care services that are available to the women, this study fulfils the following research objective, that is, to provide a detailed picture of the health needs of Ugandan rural women and the available health care services. By identifying the various unmet needs of the women from the perspectives of both the recipients (women) and providers of health care, the study fulfils the following research objective, that is, to identify the gaps in health service accessibility as perceived by the rural women on the one hand, and health care providers on the other.

Research question five was: What are the rural women's perspectives on recommendations for changes to the current health care delivery system? This question is addressed under section 4.5 of chapter four. In summary, the women recommended health education programs mainly targeted at rural communities, adding that these programs should have a special focus on women's health issues. Family Planning (FP), breast and cervical cancer education, and other aspects of women's reproductive health were particularly mentioned. In regard to FP, the women recommended that the programs be targeted mainly at men/spouses. A related recommendation was to establish specialised health care services for women, such as antenatal and maternity care in the rural areas. Another recommendation was to establish well-facilitated health care centres with well-trained resident health care providers in the rural areas. The women's recommendations served as an input for my own recommendations as presented in the following section. With this, the third objective of this research was fulfilled, that is; to recommend strategies that would improve service delivery and women's health.

6.2. Policy recommendations.

Section 5.4 presents the general recommendations for a feasible community-based health care approach. In this section, recommendations that focus on specific services are presented. Given the critical role that men play in the use of FP services, I recommend that the men be integrated as an important target population in FP programs through education and sensitisation. Through these programs, men would be educated about various aspects of FP, and at the same time, sensitised to realise that they need to change their culturally sanctioned negative perceptions about FP. The sensitisation programs may help men realise that FP is beneficial for not only the women but themselves. In a World Health Organisation's (1998) report on the progress in human reproduction research, it is stated that greater male involvement in reproductive health is needed in order to improve and protect the sexual well-being of both men and women.

Abdominal pain has been identified as one of the major contributors to rural women's morbidity. Thus, for a policy strategy that effectively deals with women's reproductive health problems, I recommend that abdominal pain be placed among the priority areas for relevant service delivery. This would call for improved accessibility to specialised services like gynaecological and other related services. As discussed earlier, abdominal pain is a result of various factors, and thus, more reliable diagnostic procedures are vital for the identification of the specific cause in each individual case. This would call for more accessibility to laboratory testing services.

Given the possibility of the important role of stress in determining rural women's morbidity, I recommend that health care programs for the women integrate services that would address this health problem. This is more so in view of the fact that currently, the relevant services are almost completely inaccessible to the women. Other than the stress-related health services, I recommend policy interventions that will focus on the possible causes of stress, such as the women's overloaded work schedules, and their economic dependence on men. This would necessitate intersectoral collaboration among different government ministries, as well as other non-governmental organisations. Further elaboration on intersectoral collaboration is provided later in this chapter.

I also recommend increased education and sensitisation programs that are mainly targeted at rural communities. These programs would necessarily focus on health problems that are important to the women, such as breast and cervical cancer, and STD's. The programs also need to focus on other health needs of the women such as FP. The need for rural women's awareness about breast and cervical cancer comes in the wake of disclosures by the women about their health conditions, as well as their perceptions about these cancers (see 4.3.1.4). As mentioned in the previous chapters, some women disclosed having experienced lumps/pain in their breasts, while several others disclosed pain in the cervical area. Although other causes cannot be ruled out, these are common symptoms of breast and cervical cancer. This situation is made worse by the perception among rural women that cancer screening is necessary only for those who suspect the disease. The above instances signal a significant risk of the women contracting these cancers. Through education and sensitisation programs, women would be enlightened about these cancers, which in turn will improve their self-monitoring ability. At the same time, the women would be sensitised to realise that breast and cervical cancers are real possibilities, and that it is necessary that they take the necessary precautions. For instance, the women should be able to conduct regular Breast Self-Examinations (BSE). Increased knowledge will also change women's perceptions from viewing cancer screening as necessary only when one suspects the disease, to viewing the screening as a regular necessity for every woman.

A related recommendation is that regular cervical cancer screening of rural women be implemented. The screening is possible even with the limited resources, since it is already provided for in the *Procedure Manual* (MOH & INTRAH, 1995). This manual lays out the procedures to be taken, from obtaining Pap smear samples from the women to sending the samples to the central laboratory in Kampala. From my interviews with the health care providers, there appeared to be no satisfactory reason why regular screening was not being done. When asked why the screening was not done in spite of the stipulated procedures, the majority of health care providers did not have a clear answer. Some of them disclosed that they did not know. Since these health care providers were selected from among those directly involved in women's services, I consider it realistic to conclude that their inability to clearly answer the question meant that cancer screening is not among their priority issues.

The STD education and sensitisation programs need to be focused not only on women, but also on men. This is because the data from this study reveal that men play an important role in the spread of STD's through extra marital sex, and the men's habitual reluctance to seek health care for themselves, and denying health care support for their spouses (see 4.3.1.1). It expected that increased sensitisation of rural men about STD's should result in their behavioural change. With the perceived importance of STD's among rural women, a related recommendation is that accessibility by the women to laboratory testing services be an urgent policy matter. Accessibility might not be fully realised due to resource limitations. However, given that these services are only available in some rural hospitals, a beginning point might be to equip the existing health care centres/dispensaries with the services, since they are more accessible to rural women.

In regard to FP, it was revealed in this study that rural women do not receive adequate counselling that would enable them to make informed decisions about FP method choices (see 4.4.5.2). Therefore, I recommend that policy measures be taken to ensure that FP service providers in the rural areas offer adequate counselling. This might be through further training and regular refresher courses for the rural FP service providers, and improved monitoring of these providers by staff from the district referral hospitals.

I also recommend that the Ministry of Health establish a more streamlined monitoring system and tighter controls on private practice. The urgent need for this measure emerged in light of indications that a number of private health care practitioners frequently do not have the proper qualifications for their fields of practice. The above recommendation is further supported by a related finding that several private practitioners seem to be pre-occupied with their business interests, which is often at the expense of the quality of care for rural women.

Drug hawkers particularly need more attention as many of them do not have a permanent physical address that would facilitate easy monitoring and control. These drug hawkers play an important role of filling the gap created by the inadequacy of formal care in the rural areas, and thus, they are an integral part of the continuum of health care providers. Therefore, it would be inappropriate for the Ministry of Health to ban their operations without considering alternatives. I recommend that the ministry strengthens the operations of Community Health Workers (CHW's), whose services in rural areas are currently inadequate. This can be realised if the CHW's are always facilitated with drugs for common minor ailments, as lack of these appears to be one of the major reasons why the women are dissatisfied with the CHW's. Additional deployment of the CHW's to the rural areas is also recommended, as this will enable the CHW's to engage in regular community outreach programs, and perhaps diminish the need for drug hawkers' services.

Refresher courses and sensitisation programs are recommended for Traditional Birth Attendants (TBA's). Among other issues, the sensitisation programs should focus on the need for prompt referral of cases with delivery complications to more sophisticated health units. Failure to refer complicated cases was identified as a major problem among the TBA's, and this has been a contributor to maternal and infant mortality in rural areas.

Apart from the recommendations directly targeted at the Ministry of Health, the majority of rural women participants consistently mentioned the need for clean water, transportation, financial support for income generating activities such as poultry and rabbit projects, and to establish a food security system. Given that these recommendations cannot be implemented solely by the Health Ministry, I recommend the strengthening of intersectoral collaboration among ministries and other non-governmental organisations (NGO's) that deal with each of the above concerns by the women. In particular, this would call for regular co-ordination/collaboration among the ministries responsible for health, water, transport, finance, and agriculture, as well as NGO's that are running related projects in the respective community.

6.3. Future research directions.

As a future research direction, I recommend that more studies be conducted on FP use and men. Support for this research, as well as others that are suggested below, might be from an established national research policy strategy with a special focus on eliminating gender inequity in health. The 1998 World Health Organisation (WHO) report on progress in human reproduction research states that one of the greatest challenges for researchers is to develop appropriate models for providing reproductive health services for men. The report adds that a crucial issue in the development of such models is how to motivate men to use the services. The WHO report identifies a series of research questions that might be relevant for this kind of research. These include: (1) How should a community reproductive health service that includes special care for both women and men be organised?, (2) Which services should be joint and which should be separated?, (3) Should male clients be seen by male clients?, (4) How do men behave if women are also around in the waiting room?, (5) Should men and women be served at different times?, (6) Should women be encouraged to bring their partners along?, (7) Should the counselling of men and women be different, or should services be designed for couples?, and (8) What kind of problems should counselling cover? In addition, this study has established that there is inadequate reproductive health care in Ugandan rural areas. Thus, as has been pointed out (United Nations, 1995, p. 78), a related recommendation is that research be done on the extent of unmet demand for safe and effective methods of fertility regulation, and the extent of unmet need for the information necessary to make free and informed choices about childbearing. This information would be useful in the design of relevant services.

Given the importance of abdominal pain as a major contributor to rural women's morbidity, I recommend more medical/laboratory studies on this health problem with a focus on rural women, in order to identify the common causes of this pain. This would enable service providers to identify specific services that require more emphasis, since the pain is a result of various factors such as STD, gynaecological, and other factors as discussed in the previous chapter. A related recommendation is that medical research be done on Ugandan rural women to produce reliable data on the STD types that are common among the women. This is in view of the perceived importance of STD's among the women and the lack of reliable data on the common STD types. This would provide information on important STD's, notably genital warts, which is caused by the human papilloma virus that is associated with cervical cancer (WHO, 1994).

I also recommend further research on the role of stress in the morbidity status of rural women as this information would serve as a vital input in designing relevant services. Raikes (1989) points out that the increasing stress placed on women, and particularly those in impoverished female headed households, indicates a particularly crucial area of study where action could be taken to improve the health status of women and their families. Recommendations flowing from this research may also yield suggestions for supporting women's organisations and collective efforts in general that can reduce pressures on rural women.

In regard to violence against women (VAW), it is recommended that the research focus be not only on the quantification of the practice, but also on the attitudes and perspectives of both the women as victims of the practice, and men. As pointed out earlier, raising the consciousness of women about the negative effects of the practice is vital for the success of the fight against VAW. On the other hand, raising the consciousness of men about this practice will win their cooperation in the fight against the practice. This cooperation is vital since the men are generally the beneficiaries of the status quo, and thus, are otherwise likely to resist efforts that threaten their dominant position.

Other than the applied future research directions as presented above, some theoretical/academic research directions are recommended in this study. One of the findings of this study was that women play a major role in domestic income generation in rural areas, while men's role is on average insignificant. This was contrary to my expectation that men play a more active role. In light of this finding, I recommend that more studies be done on the role of men in this respect. Specific issues to address would include how and where men's potential can be fully harnessed for the benefit of the family. A related issue would be to establish the dominant factors determining the provision of help from men to their female spouses. The education level of spouses, economic status of the household, age, and culture, might be some of the testable independent variables that determine the role of men in household income generation. From the available research work (see 5.3.1.1), abdominal pain might be a result of STD's, genital tract tumours, uterine malposition, and pregnancy. Future studies would focus on the above causes as independent variables, in determining abdominal pain among women. With regard to stress, future studies would focus on the role of culture, women's economic dependence, and women's daily workloads, in determining stress among women. In addition, although recommendations for a feasible community-based health care approach are made in this study, I argue that more studies still need to be done on how, in the long-run, the approach can be tailored to be sensitive to gender inequities in health.

In conclusion, the contribution of this study can be measured by checking whether the stated objectives of the study have been realised, and the study's ability to yield other unforeseen important findings that are related to the research topic. As stated in section 6.1 of this chapter, all the objectives of this study have been realised. In regard to other unforeseen important findings, this study identifies the need for emphasis on three important aspects of women's health, namely; the influence of men on Family Planning (FP) use, abdominal pain as a major cause of morbidity among women, and stress as a health problem with a possibly important role in rural women's morbidity. Although these aspects have been addressed in previous research work, this study goes beyond by emphasising their critical importance, especially in developing countries like Uganda (see 5.5.).

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APPENDIX A

Information Sheet

Research Topic: An Assessment of the Quality of Health Care for Ugandan
Rural Women, from a Gender Perspective.

Investigator: William Rutakumwa, MSc. Candidate
Department of Rural Economy
University of Alberta

Thesis Supervisor: Dr Naomi Krogman
Department of Rural Economy
University of Alberta

Purpose of Study: The purpose of this study is to assess the quality of health care for Ugandan rural women. You will be interviewed at least once, about your perceptions and views regarding the health care services for rural women in this part of Mukono District. The interview is expected to last between one half and one hour and will be audio-taped. Your anonymity will be protected by a consistent coding system and by keeping the data in locked files, to which only the researcher (I) will have access. Your name will not appear anywhere in the study.

Your participation in absolutely voluntary. During the interview, you can choose not to answer any question and you are free to withdraw from the interview if you wish. Your participation in this interview may be of no personal benefit to you, but it is hoped that your views will enable the design of better strategies for the improvement of rural women's health care services. The results of this study will be availed to you on completion of this study.

In case you have any questions about this study, you may contact me on the following address; c/o Wilson Isingoma, P.O. Box 7041, Kampala. If you agree to participate please fill in your name and signature in the space provided for you below.

APPENDIX B

Informed Consent Form

Research Topic: An Assessment of the Quality of Health Care for Ugandan Rural Women from a Gender Perspective.

Investigator: William Rutakumwa, MSc. Candidate.

THIS IS TO CERTIFY THAT I/WE,______________________, hereby agree to participate in this research study as described to me/us on the information sheet. The study has been explained to me/us and I understand that:

- -I/We will be interviewed at least once.
- -The interview duration will range from one half to one hour.
- -The interview will be audio-taped.
- -My/Our anonymity will be protected and my/our name(s) will not appear anywhere in the study.
- -My/Our participation is voluntary.
- -I/We can choose not to answer any question during the interview, and I'm/we are free to withdraw from the interview if I/we so wish.
- -Feedback on this study will be availed to me/us through the local administration system/district medical office.

______________________________	______________________________
(Name[s] of Participant[s])	(Signature[s] of Participant[s])
______________________________	______________________________
(Name of Researcher)	(Signature of Researcher)

____

(Date)

Note: You will retain a copy of this consent form, please keep it for your record.

APPENDIX C

Guiding Questions for Rural Women

1. What are the general issues/problems, if any, that trouble you in your daily life?

2. What are the health problems you usually experience in your daily life?

3. Have you always sought health care whenever you have a health problem? If not, what are those health problems for which you have sought prompt health care?

4. What are those health problems for which you usually do not seek (prompt) health care? Why do you not (promptly) seek health care in these cases?

5. How far are the nearest health care services from your home? Are you able to obtain health care during the hours the health care facility is open? How long do you generally wait to visit a health care provider? What might prevent you from using the health care services in your area when you feel you really should seek medical attention?

6. Were you satisfied with your last visit to a health care clinic? Did the health care provider request that you return to follow-up on the health problem for which the visit was made? Were you satisfied with the treatment and advice of the health care provider? If medication was recommended were you able to obtain the medication?

7. In general, do you have a preference for female or male health care providers? Are there specific health problems for which you prefer specifically a female or male health care provider?

8. Do you practice Family Planning? If no, why? If yes, what type of services do you get from the F.P. clinic? (including counselling).
   Were you asked by the provider;
   a) If you have had a recent delivery or abortion?
   b) If you have had over four pregnancies?
   c) If you are 35 years of age?
   d) If you are below 20 years of age (regardless of marital status)?
   e) If you have any medical conditions likely to endanger the mother's life during pregnancy, child birth and immediately after, e.g diabetes or heart disease?
   f) If you have HIV and/or AIDS?
   g) If you have had children within a birth interval of less than two years?
   h) If you have had a bad obstetric history which is likely to recur with future pregnancies such as post-partum haemorrhage or pre-eclampsia?

9. Have you ever suffered from an STD? If yes, which was that? Were you tested/diagnosed? If you had treatment, did you go for post-test? If you did not go for check-up how did you establish the type of STD?

10. Have you heard about cancers of the breast and cervix? If yes, have you ever taken tests for any of the above cancers? If yes, where? If no, why?

11. Have you ever been beaten by your spouse? If yes, how often?

12. Do you have Community Health Workers (CHW's) in this area? If yes, what do they do? Are you satisfied with what they are doing? What would you like them to do?

13. Reflecting on your past experiences with the health care services in your village/area, what are your recommendations to improve the services that are available to you? What changes would you like to see?

Guiding Questions for Health Care Providers

1. Tell me about your academic qualifications.

2. In general, what are the different categories of health care services offered to the rural population of Mukono District?

3. What are the services that are specifically meant for women?

4. What are the common health problems reported by the rural women?

5. What problems (if any) do you as health care providers, encounter as you offer services to the rural women?

6. What is your assessment of the health services as they relate specifically to rural women?

7. What are your recommendations for change to improve service delivery and the health status of rural women?

APPENDIX D

Written Diagnostic Guidelines

SYNDROME PRESENTATIONS OF GENITAL TACT INFECTIONS AND MANAGEMENT				
SYNDROME	**SUBJECTIVE FINDINGS (CLIENT'S HISTORY)**	**OBJECTIVE FINDINGS (PROVIDER ASSESSMENT)**	**POSSIBLE CAUSES**	**TREATMENT**
1.URETHRAL DISCHARGE *Purulent offensive discharge from the urethra. *It is the most common complaint in men with STD.	*Pus dripping from penis. *Pus discharge. *Burning pain on urination in both male and female	*Milk urethra to see the discharge which can be abundant, purulent and mucoid. *Inflammation around urethral ori-fice	A. Gonococcal urethritis (GC).	*Give single dose of any one of the following antibiotics: A.Cerfrizxone 125mgs. Intramascular-single dose. *PPF 4.8 ml units 1.m. plus probenicid 1mg orally. *Chloramphenical 2.5 gms orally for 2 days. *Cotrimoxazole 10 tablets daily for 2 days. *Kanamycin 2.0 gms intramascular injection single dose. *Spetinomycin 2.0 gms. Intramascular injection single dose. *Follow-up review 2 to 7 days after completion of treatment. *If no response to treatment suspect and treat for chlamydia.
			B. Non-gonococcal urethritis (NGU) largely due to chalmydia trochomatis	B. *Tetracycline 500 mgs orally 4 times daily for 7 days. *Doxycycline 100 mgs orally 2 daily for 7 days. *Erythromycin 500 mgs orally. 4 times daily for 14 days (Note: Drug of choice in pregnant women.)

				*Sulphamethoxale, 1.0 gms twice daily for 10 days.
SYNDROME	**SUBJECTIVE FINDINGS**	**OBJECTIVE FINDINGS**	**POSSIBLE CAUSES**	**TREATMENT**
2. VAGINAL DISCHARGE Discharge per vagina that are abnormal in colour, odour and or amount.	*Soiling of underpants excessive PV discharges offesnsive, itching, dysuria, dypareunia redness of vulva with lower abdominal pain at times.	A.*Profuse runny or malodorous discharge which can be frothy.	A.(i) Trichomonas vaginalis. (ii) Bacterial vaginosis/ gardenerella vaginalis.	A(i) *Metonidazole 500 mg. Orally twice daily for 7 days or 2.0 gms as single dose. *Clotromazole 100 mgs. Per vagina for 7 days in pregnancy. A(ii) *Metrinidazole as above. *Ampicillin 500 mgs. Orally 4 times daily for 7 days in pregnancy.
		B. *White curdlike yeasty smelling discharge which leaves raw area on when rubbed off.	B. Candidiasis.	B.*Nystatin pessaries 200,000 units inserted into vagina daily for 14 days. *Gentain violet 0.5-1% solution soaked in cotton wool, inserted into vagina daily for 3 days. *Clotrimazole 100 mags pessaries inserted into vagina daily for 7 days.
		C. *Mucopurulent offensive discharge which is coming from cervix.	C. Conococcal or nongonococcal (chlamydia) infection.	C.*Treat as above for NGU. *Advise client on personal hygiene.

SYNDROME	SUBJECTIVE FINDINGS	OBJECTIVE FINDINGS	POSSIBLE CAUSES	TREATMENT
3. LOWER ABDOMINAL PAIN Pain in the lower abdomen	*Mild to severe pain in the lower abdomen which may first be noticed during or shortly after menses. *Pain may be associated with fever and/ or vaginal discharge,	A. The following medico-surgical emergencies must be ruled out. -Ectopicpregnancy -Intestinal obstruction -appendicitis -septic abortion.		Refer immediately if any of these conditions are suspected.
		B. *Lower abdominal tenderness. *Abnormal endocervical discharge *Cervical motion tenderness. *Adnexal tenderness.	B. PID due to gonorrhoea, chlamydia, post-partum or post-abortal infections reading to salpingitis endometritis, pelvic peritonotos oophoritis, or parametritis.	B. Outpatient *Treat gonorrhoea or chlamydia as above plus tetracycline 500 mgs. Orally four times daily or doxycycline 100 mgs orally twice daily for 10 days plus metronidazole 500 mgs orally three times daily for 10 days. *Enythromycin in pregnant women. Bi. Inpatient *Chloramphenicol 500 mgs. 6 hourly plus gentamycin 1.5 mgs. Per kg. Body weight 8 hourly for 4 days (or 48 hours after patient) improves. *Followed by above treatment as for outpatient